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Resident

Physician

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Opportunities in Academic Medicine

My First Year in Obstetrical Practice

Clinico-Pathological Conference

Yale-New Haven Medical Center

A Time for Regret

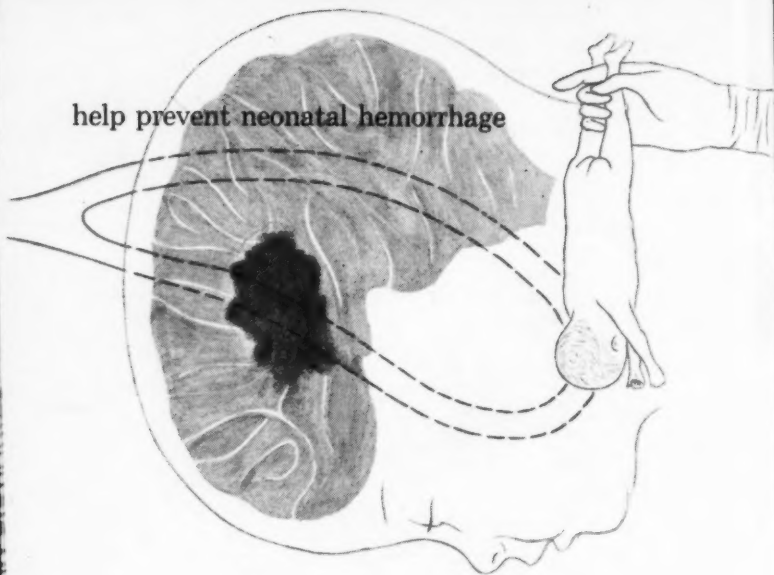
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The Doctor Makes a Speech

Journal for the Hospital Staff Officer

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*Council on Pharmacy and Chemistry: New and Nonofficial Remedies, Philadelphia, J. B. Lippincott Co., 1956, p. 505.

Resident Physician



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Resident Physician

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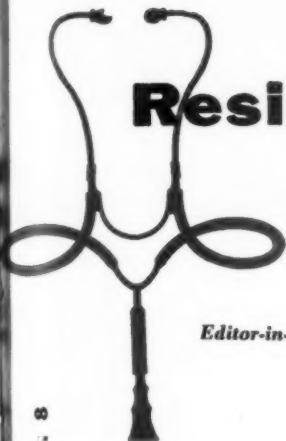
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Resident Physician



August 1958, Vol. 4, No. 8

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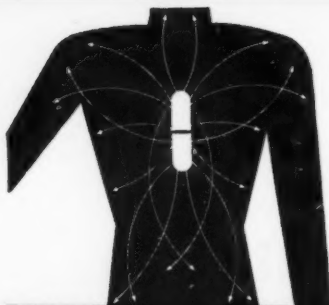
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References: 1. Welch, H.; Wright, W. W., and Staffa, A. W.: *Antibiotic Med. & Clin. Therapy* 5:52 (Jan.) 1958. 2. Carlozzi, M.: *Antibiotic Med. & Clin. Therapy* 5:146 (Feb.) 1958. 3. Nathan, L. A.: *Arch. Pediat.* 75:251 (June) 1958. 4. Shalowitz, M.: *Clin. Rev. & Res. Notes* 1:23 (April) 1958. 5. Cornblith, T.; Chesrow, E., and Barsky, S.: *Antibiotic Med. & Clin. Therapy* 5:328 (May) 1958. 6. Stone, M. L.; Sedlis, A.; Bamford, J., and Bradley, W.: *Antibiotic Med. & Clin. Therapy* 5:322 (May) 1958.

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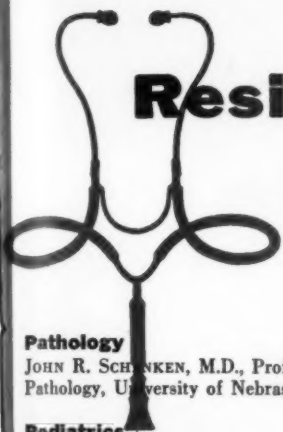
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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All of the products listed are registered trademarks, except those with an asterisk (*).

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new shampoo

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IN 4 MINUTES

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Gardner, J.: J. Pediat. 52:448 (Apr.) 1958.

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for **nausea** **and vomiting** **VESPRIN**

Squibb Triflupromazine

- postoperatively
- in pregnancy when vomiting is persistent
- following neurosurgical diagnostic procedures
- in infections, intra-abdominal disease, and carcinomatosis
- after nitrogen mustard therapy

- provides prompt, potent, and long-lasting control
- capable of depressing the gag reflex
- effective in cases refractory to other potent antiemetic agents
- may be given intravenously, intramuscularly and orally
- no pain or irritation on injection

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Intravenous: 8 mg. average single dose

Dosage range 2-10 mg.

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If subsequent parenteral dose is needed, one-half the original dose will usually suffice

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Parenteral solution — 1 cc. ampuls (20 mg./cc.)

Oral tablets — 10 mg., 25 mg., 50 mg., in bottles of 50 and 500

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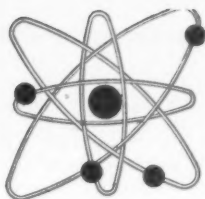


Squibb Quality — The Priceless Ingredient

"VESPRIN" ® IS A SQUIBB TRADEMARK

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center



What Is Your Diagnosis?

- | | |
|-------------------|-----------------------------|
| 1. Simple osteoma | 3. Foreign body |
| 2. Meningioma | 4. Calcified sebaceous cyst |

Answer on page 137



Comments by investigators on

Robaxin

(Methocarbamol Tablets, U.S. Pat. No. 2770540)



—the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:1027, 1958. 2. Percy, H. P.: J.A.M.A. 167:102, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Ass., Sci. Ed. 46:274, 1957. 5. O'Doherty, D. S., and Stéfida, C. D.: J.A.M.A. 167:160, 1958. 6. Park, R. W.: J.A.M.A. 167:160, 1958. 7. Truitt, E. B., Jr., and Patterson, B. B.: Proc. Soc. Exper. Biol. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, B. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:160, 1957.

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Ethical Pharmaceuticals of Merit since 1878

Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm ^{1,2,3,4}

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1¹		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2²		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3³		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4⁴		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants..."²

THE JOURNAL
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"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm..."³

THE JOURNAL
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"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes..."⁴

Southern Medical Journal

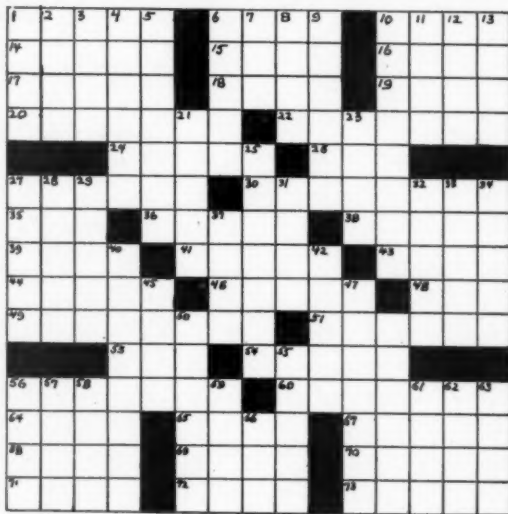
"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions..."¹

ACROSS

1. Focus of infection
2. Fibers of *Corchorus olitorius*, used in surgery
3. The ultimate of an element
4. ... helenium, elecampane; the root is a stimulant
5. The choroid, ciliary body, and iris, as a whole
6. ... of Ethics
7. Hum in a gentle tone
8. Antiseptic & antipyretic distillations from pine wood
9. An alleged natural electric force supposed to be hypnotic
10. ... Test for Hypoxanthin
11. A mixture (Lat.)
12. Moslem priest
13. Recent (prefix)
14. Pouch filled with suppuration
15. Histoid
16. ... serrata, the endings of the ligament of the lens and the retina
17. Care for the sick
18. Four (prefix)
19. Bubbling sound in the bronchi
20. Schools of belief
21. Immediately (abbr.) (Lat.)
22. Genus of plants, the true beaths
23. Source of "cat gut"
24. Mother of the ancient Irish gods
25. Recumbent (Labi.)
26. Paroxysmal headache
27. Medicine (abbr.)
28. Glass slip for microscopic specimens
29. Hemophilac
30. Any of a class of compounds derived from sugars by a replacement of a hydroxy with the amino group
31. A color of horse
32. Plan of . . . ; in craniometry, one passing through the nasion & basion perpendicular to the median plane
33. Skin disease from fungi
34. Shelter, (Fr.)
35. Weblike anatomical membrane
36. Toward the center
37. Nucleus purposus
38. Donkey (Ger.)
39. Clothes designed by a famous Frenchman

Resident Relaxer

(Answer on Page 137)



by Angela Koelliker

DOWN

1. The doctor arrives "in the . . . of time"
2. Small receptacle used by Japanese fastened at girdle
3. Duets
4. Cicatrization
5. Homo sanus
6. Art (Jap.), part of a wrestling system (var.)
7. Raisin
8. End of gestation
9. Freeing from pain
10. Dimethyl ketones
11. A kind of balsam
12. Scent, smell
13. Religious observance of Ojibway Indians for prolongation of life by use of herbs and magic
21. Small hollow or cavity
23. . . . worm, oxyuris
25. An antispasmodic from the prepuce of the musk-deer
27. Provided with sweat gland orifices
28. Violently poisonous vegetable extract (var.)
29. . . . ylate, Rheumatic Drug
31. Interlacing
32. General name for volatile oil (var.)
33. Persians
34. Fact from which conclusions can be drawn
37. Often advised for the sick
40. Universal, world-wide
42. ss. (one half)
45. Where the patient should be for 37 Down
47. Having fast (rare)
50. Form ideas
52. Twins
55. This a doctor must be to the Hippocratic oath
56. Slender wire nail
57. Projections of rounded form
58. Aures
59. . . . 's Test for Albumin
61. Preposition
62. . . . -point, punctum proximum
63. Am. engineer, inventor of diving bell (1820-1887)

OSTIC® PLASTER BANDAGES

won't give you casts this strong ↘

But they give you the strength any patient needs—and all these extras, too:

	OSTIC	Bandage B	Bandage C
Waterproof package (prevents pre-setting)	YES	NO	YES
Setting time controlled within 20 seconds	YES	NO	NO
Available in both fast and extra-fast setting	YES	YES	NO
Plaster loss less than 3%	YES	YES	YES
Nonraveling edges	YES	YES	YES
Available in colors for kids	YES	YES	NO
Colors are washable pigments (not dyes). Won't stain fabrics. No gloves needed	YES	NO	—
Special Hero Club for kids (badges, certificates boost cooperation)	YES	NO	NO

Curity®
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NECROSIS and SECONDARY INFECTION of decubitus ulcers ARE CONSTANT THREATS¹⁻⁶

The Alternating Pressure Pad

"...a very effective measure"

Eliminates decubitus dangers and discomfort

When debilitated bed- and chair-ridden patients cannot easily shift their weight, the resultant ischemia frequently produces decubitus ulcers.^{1,3,5} These gangrenous lesions are painful, persistent, and prone to secondary infection.²

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References at hand: (1) Gardner, W. J.: J.A.M.A. 154:534, 1954. (2) Anderson, W. A. D.: Pathology, p. 89, St. Louis, C. V. Mosby Co., 1953. (3) Sutton, R. L.: Diseases of the skin, p. 764, St. Louis, C. V. Mosby Co., 1956. (4) Didcott, J. W.: 386, in Conn, H. F., (ed.): Current Therapy, W. B. Saunders Co., Phila., 1957. (5) Davidoff, L. M.: 497, *ibid.* (6) Gardner, W. J. et al.: Arch. Phys. Med. Rehab. 37B:580, Sept., 1954.

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Your Wife's Talking

We have enjoyed so much your magazine ever since my husband first started getting it. I always read it through, and have found it very well written, with a minimum amount of medical jargon, and your articles are very clear and most informative.

I want to thank you especially, though, for the most refreshing article in your April 1958 issue, "Your Wife's Talking" by Elizabeth Beltran. It's the first article I've ever seen to treat the subject of the doctor's wife lightly, and I heartily appreciated it. Have been reading many articles lately in various medical publications on the duties and responsibilities of a doctor's wife and I had begun to believe that it was necessary to be a very special kind of woman to be a *good* doctor's wife—and that I wasn't one of the exalted breed! I was getting a terrible complex, worrying that I was going to some day inadvertently speak out of turn and embarrass my husband so that he could never

again show his face publicly or some other equally horrible *faux pas*. So it's nice to know that doctors' wives *can* be human, and would certainly like to see more articles in the same vein by Mrs. Beltran. I don't know how many wives read *RESIDENT PHYSICIAN* but I daresay quite a few do, and possibly some feel as I do about the role of a doctor's wife. I think that a woman's primary role is to be a grand wife. Of course, I'm very proud that my husband is a doctor, but to me that is secondary to the fact that he's my husband. Being a doctor's wife does require a few more considerations than say, being a ditchdigger's wife (no offense meant to ditchdiggers and their wives!), but, as I said, I feel that the necessary adjustments could be presented without putting the role in such a light that it appears as if the doctor's wife must be a martyr, always with a trembling smile on her face, giving her all for her doctor husband, with

—Concluded on page 36



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never a qualm or a jot of disappointment at plans gone awry, dinners burned, etc., etc.

As a matter of fact, I enjoy being a doctor's wife very much, and incidentally, also enjoy mothering three small children. At least I thought I enjoyed being a doctor's wife until I get bilious at the sight of all the well-meaning articles on how to be a good doctor's wife, etc. I expected the same kind of courageous approach when I looked at the cover of the April issue and saw the title of Mrs. Beltran's article, and, as I said, it was a most lovely surprise to find a literary doctor's wife with a sense of humor!

Many thanks to Mrs. Beltran; she has restored my self-confidence and perspective. And many thanks to you for a very interesting magazine!

Mrs. John Berman
Oakland 6, California

• *Thank you very much for your letter. From our mail, we are convinced that Mrs. Beltran struck a most responsive chord among residents' and interns' wives. We have asked Mrs. Beltran to try her hand on another article. As you may know, we are very much interested in hearing from you wives—in fact, we'd like to run an article by the distaff group each month. How about it girls? We won't make you rich with our article payment, but if accepted by our Editorial Board,*

your article will bring you some remuneration over and above the cost of your stationery and stamps.

Address any of your ideas, outlines or finished articles to RESIDENT PHYSICIAN, c/o "Your Wife's Talking," 1447 Northern Boulevard, Manhasset, New York.

No Dues—No Fees

In the March 1958 issue of RESIDENT PHYSICIAN I read your editorial in regard to residents participating in organized medicine with interest. I want to endorse your sentiments. Here in Oklahoma City we have the University Hospital as well as several affiliated hospitals with residents in training. Two years ago the County Society set up a classification of Junior Memberships expressly for the residents. There are no initiation fees or dues. This permits them to have all of the privileges, both social and scientific, of the other members with the exception of voting. Last year the State Association adopted the same plan so now the residents are members of both the County and State Societies. I send you this information with the idea that maybe other states could work out similar arrangements.

John Flack Burton, M.D.
President

The Oklahoma State Medical
Association
Oklahoma City, Oklahoma

Perrin H. Long, M.D.



Editor's Page

The Resident Gets the Autopsy

IN THIS DAY AND AGE one frequently hears the query, "What good are most autopsies when patients are dying of cancer, heart disease, or other chronic diseases in which the morbid process is so well understood?"

The question is even being raised by overworked pathologists; and at times it would appear difficult to answer were it not for one thing: *The study of a disease which produces death in a patient is never complete without an autopsy.*

It is only through this final examination that the correctness of diagnostic summaries can be checked, or evidence of collateral disease revealed. The postmortem is the final arbiter when professional differences of opinion exist relative to diagnosis.

Without question, with the exception of individuals who misinterpret the teachings of their religion as prohibiting the granting of autopsy permission by surviving relatives, permission for an autopsy is easier to obtain than it was thirty years ago. This is the result of having an increasingly medically enlightened public in this country. However, there still exists some degree of repugnance towards postmortems, and this is what the resident has to overcome when asking for permission to have an autopsy performed.

There is one prime factor which governs the obtaining of autopsies. It is the confidence and faith of the surviving relatives in the truthfulness and honesty of the physician who has been taking care of their deceased. The resident who keeps the patient's relatives properly and continually informed, who is solicitous of his patient and of his patient's relatives, who honestly shares the worries and apprehension of the patient's kin, and who makes himself a real friend, counselor and comforter of the patient's family, will under normal circumstances have little difficulty in obtaining an autopsy.

When permission is obtained, other factors must be thought of constantly. Among the first is to have the postmortem done promptly and expeditiously. One must always consider the undertaker and his part in death. He can frequently be very helpful, or a real hindrance in obtaining autopsy permission. In many cities undertakers rent their vehicles from fleet owners, and every hour that the undertaker's vehicle has to wait outside the morgue costs him money. There is a good reason, therefore, for promptness in doing autopsies. Secondly, one must never exceed the limits of the permission which has been granted. If autopsy be limited in scope, to exceed that which has been agreed to is grossly unethical and illegal. Thirdly, the resident and the pathologist must observe the dignity of the dead, and at the postmortem conduct themselves as physicians and scientists. Finally, it is the duty of the physician to report, in understandable language, the findings of the postmortem to the patient's own physician and to the surviving relatives. They have a contractual right to know the results.

Perin H. Long.



Arthur L. Kay

The Doctor Makes a Speech

Whether the content of your talk is general or technical, you'll be expected by your audience to observe certain platform proprieties—such as knowing when to stop. Here are some tips to guide you.

If we consider that persuasive remarks to a controlled audience of one or more persons is a speech, almost everyone in society engages regularly in the making of speeches.

But it is the more formal type of public speaking that concerns us here—for it is in the formal peroration that most doctors go astray.

The formal forms of speech-making are the full-scale address, chair-maning of same, after-dinner remarks, and remarks at the presentation or acceptance of an award or gift.

Robert T. Oliver¹ in an interesting social study points up the necessity of public speech to our way of life. "Democracy," he says, "may be said not so much to depend upon persuasive speech as to be persuasive speech." And, in regard to the role of the untrained speaker, "The mastery of persuasive speech cannot be considered the accomplishment of specialists, but must be an integral part of the normal requirements for civilized living."

Yet, although there is no mystery as to the requirements, there are techniques that should be learned by anyone who expects to speak before a large group.

Formal

The formal speech is the most serious public speaking challenge the doctor faces. Its three facets are subject, construction, delivery.

Ivan Gerould Grimshaw² writes that the speaker must deal with a

subject in which both he *and* the audience are interested. Librarian of Beloit College, Grimshaw suggests seven sources for material:

- general books
- periodicals
- newspapers
- encyclopedias and year books
- pamphlets
- government publications
- general and specific reference books

Edward J. Hegarty³ says, "Sprinkle it with conversation. Talk about people." Good advice? Well, what would you like to hear as a member of the audience? Surely not a solid hour of statistics without an occasional bit of relief.

Construction

Construction-wise the speech must have, as the wags say, a beginning, a middle and an ending. But it is no joke that without these clear-cut internal demarcations the speaker can lose himself. Who has not suffered through a speaker who can't find his way back from a side trip? Or one who doesn't know where to stop?

Beginning and ending are the attention-grabbers. They are carefully worded, possibly even memorized.

Grimshaw has a highly meticulous technique for speech-writing. It involves note-taking on cards, the assembling of a card file, the preparation of *three* drafts of the speech.

But most speech counselors advise only a synopsis of the salient features.

Delivery

The delivery of a speech, as everybody knows, can make a mediocre speech exciting or a good one a crashing bore. Eugene E. White and Clair R. Henderliden⁴ warn that reading from a manuscript is to be advised only for those who are adept at it. It is too inflexible a medium. Allowing no room for spontaneous insights gained in the course of the speech, it prevents the intimacy, the all-needed rapport of speaker with audience. An outline resting in view on the lectern, however, is another matter.

The language of the speech is delivered in short, clear sentences and is unimpeded by either involved vocabulary, slang or clichés.

William G. Hoffman⁵ has this advice for the manner of the delivery. "Your voice should be of moderate speed and volume, never shrill, thin, hurried or too slow. Don't put your hand to your face or over your mouth. Don't walk from side to side. . . . Don't take uneasy steps back and forth. Don't lean backward or rest too heavily on your heels. . . . What to do about the hands is a problem for many speakers. They put them in their pockets, behind them, across their chests, anywhere except where they naturally belong—at their sides."

Wilfred Womersley⁶ writes that lack of audibility is a common fault. Speak, he says, as if to the person farthest away. In gesture be natural, spontaneous. In walking to the po-

dium, take your time, set your notes down, acknowledge your chairman, smile, be relaxed.

Fright

Lawrence W. Rogers⁷ offers a five-point program for overcoming stage-fright:

- Prepare your message well.
- Concentrate on what you are going to say.
- Show enthusiasm for your subject.
- Remember that your listeners have no copies of your speech.
- Your life is not at stake.

If you need more help, try Martin J. Kohe's⁸ seven aids to self-confidence:

- Have something definite to say.
- Think it is easy and you can.
- It is perfectly natural to be nervous before you start to talk — as soon as you get started, the nervousness will gradually leave you.
- Relax your hands.
- Breathe deeply.
- Stand still before you start to talk.
- Start to talk slowly.

Pronounce

We should like to interpolate here from our own past experience as newspaper reporter of many a lecture and banquet. The swayer — back-and-forth or side-to-side — is a major menace of the podium.

And the arty pronouncer is as wrong as the malpronouncer. We recall wryly the esthete, on the oc-

casional of our late arrival, whose "yoomans" baffled us until we recognized it not as the name of a popular composer but the speaker's version of "humans."

Hegarty says, "Write it to Joe." Tell it to him that way, too. (To insure correct but sensible pronunciation, the speaker might well deliver his talk first to a particularly forensic friend. He is advised also to buy, browse through and use discriminatingly the excellent compendium of commonly pronounced and mispronounced words of the National Broadcasting Company.⁹)

Questions

One possible final problem remains for the speaker when his talk is done. If a question period follows, he will have to answer or parry questions to his audience's satisfaction. He may be judged here so



harshly that his fine speech is nullified. Alfred Tack¹⁰ suggests for difficult questions that the speaker either relax the audience by using the agreement technique or ask the questioner to expand and further expand his viewpoint until its own faults become evident. The speaker can admit to not knowing an answer. He can disregard or smile at the foolish or insulting question. *He can never become angry.*

Chairman

The art of being successful chairman to a speech—or m.c. at a banquet—calls for considerateness as much as skill. Mr. Tack describes entertainingly the wrong kinds of chairman. They are The Flatterer (self-descriptive), The Director (he tells the audience what they should expect the speaker to say), The Thief (he explains the material of the speaker as he introduces him), The Humorist (he keeps telling funny stories, to steal the limelight), The Chairman-Speaker (he makes the speech himself), The Weak Chairman (he lets things get out of hand), The Seeker (while on the platform preparatory to his introduction of the speaker, he beckons or talks to someone in the audience or on the platform, holding up the main speech with his distractions).

The Ideal Chairman, says Tack, is firm and friendly. He has thought things out in advance. He has his facts right and presents them briefly.

He doesn't try to steal the limelight—in fact, he would rather move off the platform and so leave it to the speaker. He knows the rules and he keeps to them. His aim is to be a good host.

After-dinner remarks

The after-dinner speech is one of the most common of the various types of occasional speech. Probably all civilized and barbaric people engage in after-dinner speaking, say White and Henderlinder. In America, particularly, do we seem to be habituated to it.

Kohe offers the following for those invited to a dinner who sense a likelihood of being called on:

- Go prepared to say a few words.
 - Go to the chairman of the banquet and talk to him.
 - In case someone before you says something you wanted to say, agree by repeating what has been said, thus flattering the honored guest. Don't be speechless.
 - Try to be original.
 - Have a story ready.
- Jessie Haver Butler¹¹ in her charming book advises:
- Don't jump up too suddenly—take it slowly.
 - Don't apologize for lack of preparation or ability as a speaker.
 - Don't abuse the supposedly humorous story.
 - Don't speak too long. "If you don't strike oil in the first two minutes, stop boring," she quotes a Professor Roberts.

Give or get

In tendering a gift to someone, an event which calls for appropriate remarks, Mrs. Butler warns that it is not wise to overpraise the individual or the organization—or over-stress the gift or the value of the gift.

And the recipient of gift should not say, "This is more than I expected" or "I don't deserve an honor as great as this." Be natural. And, of course, be brief.

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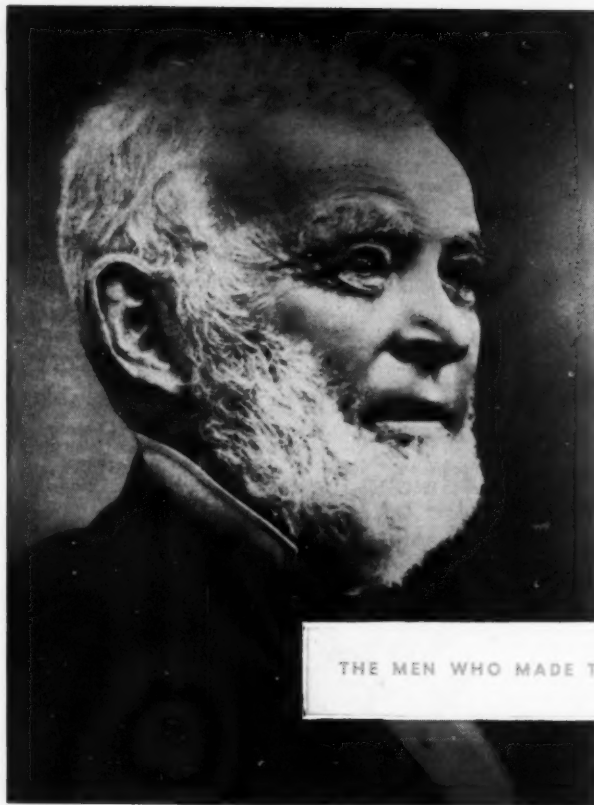
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Dr. Edward
Robinson Squibb

THE MEN WHO MADE THE MEDICINE

an honest man...

A MASTER

ward
on Squibb

Though life in mid-nineteenth century America undoubtedly had much to recommend it, it was not a reassuring time medically.

In 1858, when Dr. Edward Robinson Squibb first set up his laboratories, medicine in this country—as everywhere else throughout the civilized world—had barely emerged from the realm of folklore and witchcraft, and was acquiring scientific stature.

Modern physiology had been founded by Claude Bernard, and the invaluable practice of keeping accurate medical statistics had been started by Louis. Laennec's invention of the stethoscope added another tool to the physician's bag, but the first thermometer—a formidable instrument ten inches long, containing a couple of ounces of mercury—did not make its appearance until 1886, in England.

Virchow's *Die Cellularpathologie* recently had focused attention on the cell as the primary structure involved in disease processes, but bacteriology awaited its Pasteur, and surgery its Lister, who in 1867 would teach the rudiments of asepsis.

As for the drugs of the period, clinical observation and the keeping of records gradually were weeding out the mass of useless remedies which had been accumulated

***Although critically
burned when his
laboratories
were destroyed by fire,
Dr. Squibb saved
the formulas which
would bring help
to millions.***

ICINE

FORMULA



The Men Who Made the Medicine

over many centuries, leaving a few specifics—chiefly quinine and mercury—of demonstrated value.

This process was well under way by 1860, when Oliver Wendell Holmes wrote:

"I firmly believe that if the whole materia medica as now used could be sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fishes."

Yet there were two great triumphs of early 19th century medicine which more than made up for its numerous faults and misconceptions. The first was the accurate observation by Oliver Wendell Holmes in America and the later clinical proof of Ignatz Semmelweis in Vienna that puerperal fever, which made childbirth such a lethal undertaking, was needless infection.

The second great triumph was ether. Prior to 1846, when the value of ether was first recognized, heavy doses of opium, alcohol or nicotine were administered to patients before operations. But in many cases, especially when time was short, the victim was operated upon without any attempt at numbing the pain.

In 1846, however, Dr. W. T. G. Morton of Massachusetts made the first important public demonstration of anesthetic ether for the medical profession at the Massachusetts General Hospital. Morton's anes-

thetic was crude sulphuric ether disguised with aromatics. He called it letheon, because ether itself was in some disrepute, having previously been used as an intoxicant.

Ether

But the mere demonstration of the anesthetic value of ether did not automatically make the boon available to everyone. On the contrary, many surgeons would not accept it. This was because the early ether was so unreliable. It was likely to contain toxic impurities, and was highly variable in potency.

The fault lay partly in the method of manufacture, and partly in the fact that the liquid deteriorates rapidly in storage unless kept in proper containers. Thus it was difficult to control the depth of anesthesia, or, for that matter, to be sure of just what vapors the patient might be inhaling. Under such conditions the merciful anesthetic might become an added danger.

It fell to Dr. Edward Robinson Squibb to make the crucial improvements in the production of ether which gave the world a safe, effective, controllable anesthetic. Originally, batches of ether were made in crude stills over open fire—an extremely dangerous process, and one in which the quality of the end product never was predictable.

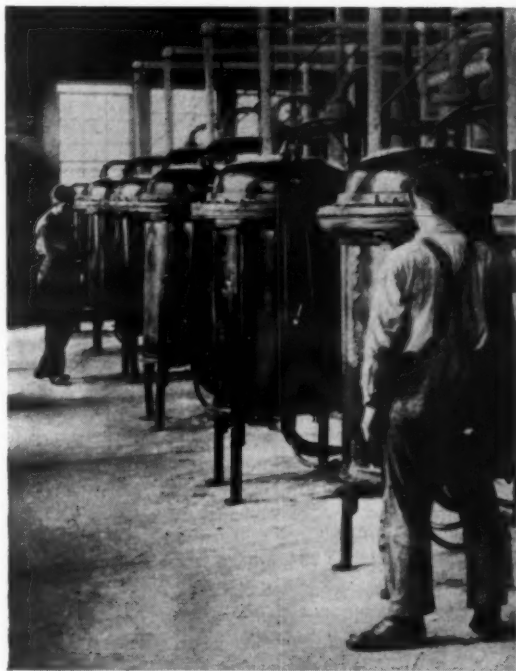
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Stated in the simplest terms, Dr. Squibb's contribution was the invention of an improved, closed still and a process of distilling ether continuously by steam.

This eliminated the constant hazard of fire and explosion in the older process, and—much more important—made it possible for the first time to produce pure anesthetic ether of consistent strength. It was

a work which occupied years, and required the building of at least 20 stills before Dr. Squibb was finally satisfied. Unwilling to make personal capital out of the new process, he published a full account of it in the September 1856 issue of the *American Journal of Pharmacy*, complete with drawings and diagrams, operating directions, formulae, and cost estimates.

The basic design of Dr. Squibb's original ether stills proved sound. The 1910 stills shown here differed only slightly from the earlier models.





The Men Who Made the Medicine

Anyone was free to use the process, and it is said that Dr. Squibb once loaned some of his apparatus to a competitor, to help him get started. But the excellence of his own product defeated competitors. Interestingly enough, ether today is made by virtually the same process which Dr. Squibb perfected in 1852.

Quaker

Dr. Edward Robinson Squibb by this time was 33 years old and already well on his way to becoming one of the notable scientific figures of his generation. He was born in Wilmington, Delaware, in 1819, of Quaker parents. From them, and from the circumstances of his early life, he acquired ingrained habits of thrift, perseverance in his work, a contempt of sham and show, and utter personal and professional integrity.

"Be true as the needle to the Pole" was one of his favorite sayings, but his own character was a great deal more consistent and dependable than the magnetic compass. All his life he retained the quaint manner of Quaker speech, with its "thees" and "thous." "Thee is a fool!" he would reprove a bungling laboratory helper.

Young Squibb dreamed early in life of becoming a physician, and to make this possible he served five

years as an apothecary's apprentice in Philadelphia. Out of his meager pay he saved enough to enter Jefferson Medical College, where he graduated with high honors in 1845. Afterwards he remained at the college for two years as an instructor.

Naval duty

With the outbreak of the Mexican War, Dr. Squibb became an assistant surgeon in the navy, first serving for two years on the brig *Perry* in Mexican and South American waters, then making a cruise to the Mediterranean on the storeship *Erie*. Shipboard life did not appeal to him, but this period had an important effect on his later career.

During his apprenticeship, Squibb of course had become aware of the untrustworthy nature of the medicines which he and his apothecary employer compounded. The fault was in the crude drugs then available. Mostly imported, they came into the country in bulk, and were liberally mixed with dirt and foreign matter such as twigs, grass, nails. There were no legal pharmacopoeial standards as we have today, and the drugs were vaguely designated according to their vegetable or mineral origin. Standards of potency didn't exist; three ounces of a given drug from one lot might not be equal to a half ounce from another.

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With such raw materials to work with, it clearly was impossible for any pharmacist to make up an accurate prescription. The proof of the prescription was its effect on the patient. If the medicine helped him, well and good; if not, it was too bad, but nobody could be blamed.

Squibb considered all this deplorable, and made up his mind to try and do something about it. But now that he was a full-fledged assistant surgeon, with patients of his own to treat, it was intolerable. Like all other government agencies, the navy purchased drugs the way it purchased gunpowder and other ship's stores—from the lowest bidder, with few, if any specifications of quality. Dr. Squibb knew that the medicines he prepared from these drugs were of extremely doubtful value, and he reported as much to the navy.

Drug research

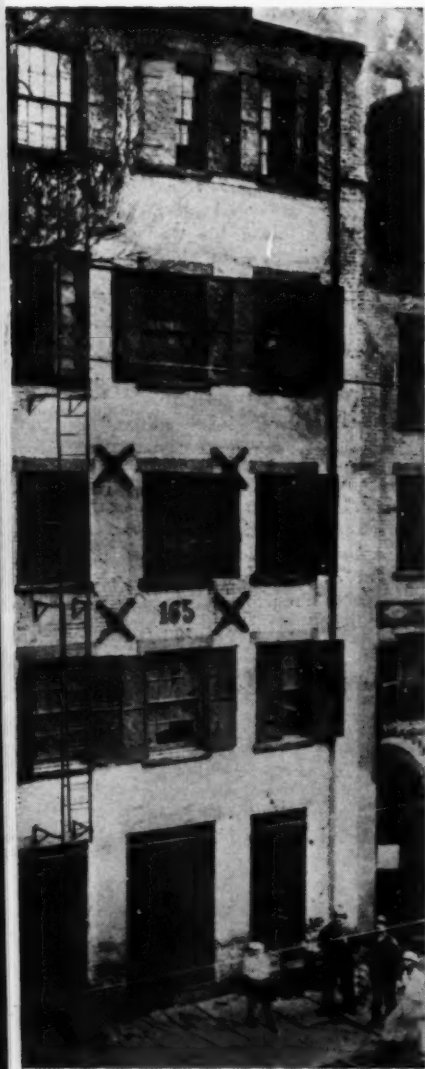
Coming from a minor medical officer, this pure-drug agitation at first had no effect, but after Squibb was transferred to shore duty and assigned to the Brooklyn Navy Yard his ideas were heeded. In 1852 Congress appropriated limited funds to establish a naval laboratory for drug research, and in a small room above the morgue in the naval hospital, Dr. Squibb went to work, with

TO BENEFIT ALL

He had unusual mechanical ability and loved research, and he abhorred secrecy, freely disclosing his discoveries to all, even to competitors . . . His *Ephemeris*, a periodical dedicated to medicine and pharmacy, was unique and characteristic. It disseminated thousands of pages of the most useful and practical drug information and was issued gratuitously . . .

Squibb had striking individuality. "He consecrated his life to the object of furnishing honest medicines for the relief of disease, and naturally his laboratory work had the first place; morning, noon and night found him there . . . He never hesitated to share with others the benefits of his great ingenuity and wide experience, so that his services to his profession were far reaching, not only on account of the enormous volume of work he accomplished, but also, because he enabled others to do much." (Joseph P. Remington)

*From The First Century of
the Philadelphia College
of Pharmacy, 1821-1921*



equipment of his own design and some of his own construction.

Research was only one of a number of duties, which included serving as physician and surgeon in the hospital, supervising the employees, looking after repairs, and on occasion even ordering food and preparing menus. It was not in his character to shirk any job that was pressed upon him and consequently he always was overworked.

"I seem destined always to have some troublesome and thankless office," he wrote in his diary. "For it is impossible to refuse such things except one selfishly says that he is not willing to take a little trouble for the sake of accommodating his neighbors."

Although he was dependent on congressional appropriations and therefore on the goodwill of various officials, Squibb never lost any of his independence nor would he make concessions for the sake of expediency. This quality he retained all his life as is indicated by the story that is related of a high-ranking officer who once playfully complained that he couldn't get his

Dr. Squibb set up his original laboratory in Brooklyn, N. Y., in 1858. A fire in which he was maimed put him out of business, but devoted friends helped him to get started again.

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The Men Who Made the Medicine

finger through the neck of one of Squibb's bottles.

"You are in error, my dear sir, in supposing this to be a veterinary product," Squibb replied. "It is intended solely for human use, and I had never contemplated a jack-ass getting his forefoot into it."

Resignation

But in spite of his contributions and discoveries, Congress refused to vote more than niggardly appropriations for the laboratory. Dr. Squibb's work was hampered by lack of funds, and there was no chance for expansion. For a while he contemplated going into private practice with a friend in Georgia, and though he decided against this, he was waiting for an opportune time to resign from the navy.

It came in 1857, when the Chief Medical Purveyor of the U. S. Army proposed that Squibb establish his own laboratories. Foreseeing armed conflict between North and South, the army for a long time had been trying to create a reliable source of supply for drugs and anesthetics, but had not succeeded in getting an appropriation through Congress. Now, Squibb was told, if he would open his own laboratory with private capital, the army could buy the bulk of his output, and he would find a market for the remainder among the medical profession.

With this encouragement, Dr. Squibb offered his resignation to the navy on September 1, 1857, and on December 4th learned that it had been accepted.

He had no difficulty in raising capital, mostly among professional friends in Brooklyn, and late in the summer of 1858 he commenced equipping the laboratories of "Edward R. Squibb, M. D." in a small brick building a short distance from his home.

It was his custom to work all day, go home for dinner, and then return in the evening for more work. On Christmas Eve, 1858, he followed this practice as usual. The laboratory was now nearly completed, and in a few weeks would be in full operation. But even as he worked there that evening, putting the finishing touches on some pieces of apparatus, tragedy was waiting to blast all his plans and nearly destroy the man himself.

Fire

An assistant carelessly tipped over a bottle of ether, and the explosive fluid spilled near an open flame. In a matter of minutes fire spread through the laboratory. Squibb's first and only thought was of the records he had arduously accumulated over the years — the formulas, tests, and experimental data which represented his life's work. Disre-



The Men Who Made the Medicine

garding his own safety, he dashed through the flames and rescued an armful of the precious notebooks. By the time he reached the street most of his clothing had burned away, and his hands and face were badly seared.

Dr. Squibb recovered, but both his eyelids had been destroyed, and for the rest of his life he wore dark glasses to protect and conceal his painfully watering eyes. At night he covered them with a pad in order to sleep. The use of his hands he regained only by enduring painful flexing exercises of his fingers, but one hand was injured so badly that later it had to be amputated. His altered appearance made him sensitive about meeting people, and thereafter he avoided going out in public as much as possible.

None of his physical suffering, however, hurt him as much as the destruction of the laboratory and the consequent indebtedness to his friends who had supplied the money to build it. But as he lay at home, slowly recuperating, a letter arrived which restored his hope. A group of doctors and surgeons had banded together and subscribed nearly \$2,100 to help Dr. Squibb re-establish his laboratory.

Back in operation

By the end of 1859, his laboratory again was in operation, and at

the time of the outbreak of the Civil War was in a position to meet many of the needs of the Union Armies. Indirectly, he helped the Confederate Armies as well, for a good share of his ether found its way into the South. It is said that even Abraham Lincoln himself chose to overlook the smuggling of Squibb ether to the Confederacy.

The war years of course brought a vast expansion to the business, and Dr. Squibb was under constant pressure to increase production. Sometimes persons unfamiliar with his methods and principles suggested compromises or shortcuts to accomplish this.

A green employee once pointed out that a slight change in a certain formula would save money and speed production, and that "no one would know the difference" in the final product.

"Young man, I am always willing to change a formula when I can improve it," Squibb told him. "But please remember that the master formula of every worthy business is honor, integrity and trustworthiness. That is one formula I cannot change."

An inventory of Dr. Squibb's accomplishments between the end of the war and his death in 1900 would fill many pages. Suffice it to say that the laboratory flourished, and that he and his co-workers, includ-

ing his sons Charles and Edward Squibb, maintained their record of leadership. It was the character and personality of Dr. Squibb himself, the example he set and his endless devotion to the scientific cause which—as much as his chemical and pharmaceutical discoveries—made his name great.

Sons manage

During the closing years of his life, Dr. Squibb's health was not adequate to the task of running the company. Management fell largely to his sons, and in 1895 the firm became known as "E. R. Squibb & Sons." However, he never lost his enthusiasm for research, and continued his experimental work almost until his death on October 25, 1900.

In an obituary published in the minutes of the Committee on Revision of the U. S. Pharmacopoeia, the following was written: "Thus has passed away from this life Edward Robinson Squibb. Pharmacy has lost a Nestor, medicine a leader, and the world the noblest work of God—an honest man."

A business created by one man and dominated by him over a long period of time usually runs into difficulties after his death. Often such a business cannot survive at all, and simply dissolves and disappears. In the case of the Squibb Company there was no problem of

survival after 1900, but admittedly there was no one to take Dr. Squibb's place.

For five years, E. R. Squibb & Sons maintained the status quo. The company lost no ground, but neither did it make any appreciable progress. Manufacture and distribution still were on a small scale, compared to what they are today, and consequently Squibb products were not widely available.

"You can't expect all your customers to come to Brooklyn," a wholesaler told Charles Squibb. "You've got to sell your medicines so that people can get them anywhere." Toward the end of his life, Dr. Squibb often had been urged to sell the business, but he never consented. But afterwards, the Squibb family realized that both new capital and new management were needed.

Transition

Lowell M. Palmer and Theodore Weicker were the men responsible for the transition of E. R. Squibb & Sons from a one-man enterprise to a big business. Weicker had come to the United States in 1887, having had long experience in the drug business abroad. He took degrees in pharmacy and pharmaceutical chemistry at Columbia, and later became a trustee of the Columbia College of Pharmacy.



The Men Who Made the Medicine

When the opportunity came in 1905 he joined Lowell M. Palmer, prominent industrialist, in the purchase of the Squibb Company. As vice-president, Weicker took over the direction of marketing and planned the Company's scientific expansion, while Palmer, as president, assumed the responsibility of financial management.

Both men were thoroughly familiar with Dr. Squibb's principles and methods, and were determined to maintain them. Therein lies the explanation of how E. R. Squibb & Sons grew to its present stature without losing any of the unique characteristics of the old regime.

New Jersey site

Some few years after E. R. Squibb & Sons was incorporated in 1905, land was purchased at New Brunswick, New Jersey, for the establishment of the ether plant. Shortly thereafter, the Squibb Biological Laboratories were established at this same location and in 1915, Dr. John F. Anderson, then director of the Hygienic Laboratory (now known as the National Institute of Health, United States Public Health Service) was appointed by the Squibb management as director.

World War I opened up broad new avenues of medical progress. Prior to the war, the arsenical

preparations indispensable in the treatment of syphilis were a monopoly of the German drug cartel and hence had to be imported. When the British blockade cut off the normal flow of commerce, small supplies were smuggled into New York on German U-boats.

With America's entrance into the war, the German patents were taken over by the Alien Property Custodian, and E. R. Squibb & Sons, among others, commenced the manufacture under license of the badly needed arsenicals, in addition of course to supplying huge quantities of other drugs and anesthetics to our armed forces.

With the opening of the Squibb Institute for Medical Research at New Brunswick in 1938, E. R. Squibb & Sons created one of the great centers of its kind in the world. Professor August Krogh, 1920 Nobel prize winner in physiology and medicine, stated at the dedication of the Squibb Institute that "... in my opinion (it constitutes) the highest level of cooperation between science and industry so far attained."

Research channeled

Research in the Institute is channeled through nine divisions—pharmacology, microbiology, toxicology, biochemical research, organic chemistry, medical chemistry, chemical

development, analytical and physical chemistry and pharmaceutical research. Additionally, a good proportion of research projects is carried out in collaboration with outside workers. The Institute's research efforts today call on the energies of more than 500 people in the search for new and better products and for answers to age-old problems of disease.

Where 100 years ago research was chiefly in the technical application of knowledge, in procedures and methods, today it ranges over almost the entire scientific spectrum and is probing constantly into new areas to add knowledge to the armamentarium of medicine.

Since the establishment of the Institute, a substantial part of the earnings of the company have been placed at the disposal of research teams engaged in a wide variety of projects. Many new products, such as forms of curare, penicillin, penicillin-streptomycin combinations, and dozens of others have been created or developed.

Industrial complex

There are a great many things about the House of Squibb which would amaze its founder if he returned for a visit today. The tremendous growth and expansion of the company he would find hard to believe. The new machines and in-

tricate processes in the New Brunswick and Brooklyn laboratories would be largely unfamiliar to him. The complicated research apparatus in The Squibb Institute might well amaze him and would certainly arouse his curiosity.

Hundreds and hundreds of the names in the current Squibb list of products would be meaningless to him. For example, with the exception of cod liver oil, he would have heard of none of the vitamin preparations. Ehrlich's famed "606," first of the arsphenamines, was 11 years in the future when Dr. Squibb died; and nearly 30 years were to pass before Dr. Alexander Fleming observed the bactericidal qualities of *Penicillium notatum* when by accident a spore of the mold contaminated a culture in his laboratory.

The sulfas and antibiotics of course were undreamed of; likewise allergens and the active principles of glandular extracts. Dr. Squibb may well have been aware of curare, but only as an exotic poison used by South American savages on their blow-gun darts, not as a valuable adjunct to anesthesia.

Through mergers in 1952 and 1954, Squibb today is an operating division of a vast industrial complex, Olin Mathieson Chemical Corporation. But its individual identity and its traditions of integrity and quality products remain unchanged.



YALE
NEW HAVEN
MEDICAL
CENTER

ONE OF A SERIES
ON LEADING
MEDICAL CENTERS

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Offering integrated clinical and didactic programs for 125 residents and 50 interns in 19 specialties, this 800-bed center also supports an extensive clinical clerkship of Yale's third and fourth year medical students.



In 1826, five professors of the Yale School of Medicine applied for a hospital charter. They argued that not only would they be able to teach their students more effectively but that their patients could also be given better care.

Each professor pledged 10 percent of his annual income for five years, or \$100 a year, whichever was larger.

New Haven was then a busy port of some 10,000 persons. And though there was a thriving trade with the West Indies, money was hard to come by for such an unheard of purpose as the construction of a teaching hospital; seven years passed before the new hospital finally opened its doors. With a capacity of 75 beds, it was situated on a hilltop site now occupied by the present Yale-New Haven Medical Center, a few blocks from historic New Haven Green.

During the Civil War a 1,500-bed military hospital was established there, and it is interesting to note that of 23,340 soldiers treated, there were only 185 deaths "and 11 of these were accidental."

Following the Civil War, expansion of the civilian facilities was undertaken so that on the occasion of the Hospital's centenary in



1926 it had cared for 6,425 inpatients, a figure which has since quadrupled.

Extensive additions to both Hospital and Medical School plants have been fairly continuous since the late 20's so that today the Medical Center occupies all of four city blocks and parts of three others.

Advantages

Situated in the heart of a New England city of 165,000 where current extensive slum-clearance is providing both a pleasant outlook and extensive modern housing facilities, the Medical Center enjoys advantages not usually found in metropolitan locales. Many of its patients today are from families whose care at the Center extends back for generations, as medical records attest. Yet the two-and-a-half-century-old university offers educational and recreational facilities second to none on its conveniently compact campus.

Community

The Yale-New Haven Medical Center offers an unusual combination of opportunities for resident training in that the teaching hospital, Grace-New Haven Community Hospital, is a true community hospital, owned and operated by a community board of directors, rather than a university-operated facility. For a century and a quarter the Hospital and Medical School have operated together in an harmonious affiliation; community doctors and University full-time professors share the teaching, service and research functions.

The financial pattern set originally by the five founding professors has been followed over the years; many of the buildings now operated by the Hospital were constructed with funds secured by the University. The most recent large addition to facilities, the Memorial Unit of



Yale-New Haven Medical Center. At left is the x-shaped Grace-New Haven Memorial Hospital. Newer buildings include Yale School of Medicine's Harkness Hall dormitory and School of Nursing. School of Medicine (round dome) is behind the New Haven unit of the Hospital.

Grace-New Haven Hospital sees an average of 80 patients a day in emergency. Here, resident helps accident victim.



**GRACE-NEW HAVEN COMMUNITY HOSPITAL
RESIDENTS AND INTERNS 1957-1958**

SPECIALTY	INTERNS	1ST YEAR ASS'T. RES.	2ND YEAR ASS'T. RES.	3RD YEAR ASS'T. RES.	RESIDENTS
ANESTHESIOLOGY	—	4	4	—	1
INTERNAL MEDICINE	18	8	8	—	1
OBS.—GYN.	—	4	4	2	2
PATHOLOGY	6	2	—	—	1
PEDIATRICS	8	5	3	—	1
PSYCHIATRY	—	14	5	—	1
RADIOLOGY	—	3	3	2	1
GENERAL SURGERY	15	8	8	8	1
CARDIOVASCULAR SURGERY	—	—	—	—	1
THORACIC SURGERY	—	—	—	—	1
NEUROSURGERY	—	—	1	—	1
ORTHOPEDICS	—	—	2	—	1
UROLOGY	—	—	1	—	1
OPHTHALMOLOGY	—	1	1	—	1
OTOLARYNGOLOGY	—	1	1	—	1
DENTAL SURGERY	2	—	—	—	—
DERMATOLOGY	—	1	1	—	—
NEUROLOGY	—	1	1	1	—
PHYS. MED. & REHAB.	—	1	—	—	1
	49	53	43	13	17

the Hospital with 338 beds and 112 bassinets, was financed by local subscription, while the new Hunter Radiation Therapy Center is currently being constructed with more than \$1 million raised jointly by Yale and the Hospital.

Graduate programs

The character and quality of intern and residency training pro-

grams are determined by the Medical School. Interns and residents, while rendering service in caring for hospital patients, at the same time are pursuing a program of post-graduate medical education. In recognition of this dual responsibility, residents and interns of Grace-New Haven Community Hospital not only receive appointments on the Hospital house staff but are also enrolled

as postgraduate students in the School of Medicine.

In addition to the 175 residents and interns enrolled as postgraduate students, the School of Medicine also offers educational opportunities for postdoctoral clinical and research fellows. Fellowships are available in all clinical departments for properly qualified individuals.

The Yale Department of Public Health has pioneered for many years in bridging the gaps between medicine and the sociological sciences. Courses in public health leading to the master's or doctor's degree are offered to physicians, dentists, nurses, engineers, educators, statisticians, bacteriologists and hospital administrators who come each year from all parts of the country and from around the world.

Clinical material

Although the Yale-New Haven Medical Center serves primarily all of Connecticut and southern New England, many of its patients come from distant states and foreign lands.

Since there has never been any tax-supported "city hospital" in New Haven, for many New Haven families the resident physician in the clinics and wards of the Hospital functions as the "family physician." This arrangement provides a continuity of followup which is valuable to a training program.

In addition, more unusual cases and problems of special interest are

referred by physicians throughout southern New England for diagnosis and treatment. The house officers are thus provided with a wide selection of clinical material representing all economic strata. Since third and fourth year medical students serve as clinical clerks on the Hospital wards, the resident staff is relieved of much routine work.

Census

Hospital beds number 818, including 112 bassinets and 44 beds in the affiliated psychiatric facilities. In the past year there were 24,587 admissions and 77,391 outpatient clinic visits. Approximately 13,000 surgical procedures are performed annually. Births are increasing each month; the present rate exceeds 4,500 annually.

The average daily census is 508, excluding newborn and psychiatric, with approximately 30 percent of the patients on ward service. However, all patients are available for the undergraduate and postgraduate teaching programs.

Autopsies last year numbered 785 at a rate of 68 percent.

A growing problem, especially in general surgery and the surgical specialties, is the maintenance of a sufficient population of ward patients to provide a satisfactory experience for all residents. With the rapid extension of hospital insurance plans, the shift from ward to semi-private and private is a nationwide phenomenon that is apparent

YALE-NEW HAVEN MEDICAL CENTER SCHEDULE

(Held weekly except as otherwise noted)

ANESTHESIA

DAYS

Staff Conference	Tues.
Basic Science Seminar	Tues.
Clinical Science Seminar	Wed.

COMBINED THORACIC CONFERENCE

Fri.

INTERNAL MEDICINE

Clinic for Students	Thurs.
Grand Rounds	Sat.
Medical Section Meeting	3d Tues. alternate months
Grand Rounds	Thurs.

OBSTETRICS AND GYNECOLOGY

Gynecological Rounds	Mon., Fri.
Clinic for Students	Tues.
Obstetrical Rounds	Tues.
Departmental Conference	1st, 2d, 3d, 4th Thurs.
Grand Rounds	1st, 2d, 3d, 4th Thurs.

OTOLARYNGOLOGY WEEKLY CONFERENCE

Wed.

PATHOLOGY

Demonstration Gross Autopsy Material	Mon., Wed., Fri.
Staff C.P.C.	Mon.
Surgical Pathology Demonstration	Wed.
Student C.P.C.	alternate Wed.
Staff Seminar	alternate Thurs.

EDUCATIONAL CONFERENCES

PEDIATRICS CONFERENCE FOR PHYSICIANS

Wed.

PHYSIOLOGY SEMINAR

Wed.

PSYCHIATRY

Research Seminar

Thurs.

Clinic for Students

Fri.

PUBLIC HEALTH SEMINAR

Fri.

RADIOLOGY

Orthopedic X-ray Conference

Daily

Pediatrics X-ray Conference

Tues. and Fri.

Cardiovascular Conference

Wed.

Staff X-ray Conference

Thurs.

Neurosurgical X-ray Conference

Fri.

Daily X-ray Review

Mon., Tues., Wed., Thurs.

SURGERY

Urological Staff Conference

Mon.

Tumor Conference

Tues.

Clinic for Students

Wed.

Grand Rounds

Sat.

Surgical Staff Conference

2d Mon.

Surgical Pathological Conference

1st & 3d Tues.

Surgical Conference

Thurs.

X-ray Conference

Fri.

Surgical Rounds

Sat.

Tumor Conference

2d & 4th Tues.

Typical nursing station, at GNH Memorial Unit. At right is view of the modern, spacious Hospital library.



in all but government-controlled hospitals.

Complete integration with the West Haven Veterans Hospital of the residency training program in medicine, surgery and certain specialties has served to provide more abundant and varied clinical material.

The West Haven Veterans Hospital, located three miles from the Medical Center, is a new facility opened in 1953. It has a bed capacity of 880 and has psychiatric and pulmonary disease services in addition to active, acute medical and surgical services.

Psychiatry

In psychiatry, an extensive program utilizes the facilities of the Grace-New Haven Community Hos-

pital, the Yale Psychiatric Institute and the West Haven Veterans Administration Hospital. The minimal duration of training for qualified students is three years and includes clinical experience, seminars in basic sciences and participation in the research program. Emphasis is on the concepts and practical application of dynamic psychiatry.

The psychiatric outpatient clinic of the Hospital offers abundant clinical material for training in the practical and theoretical aspects of brief and long-term psychotherapy of nonhospitalized patients. The residents may also be assigned to the Yale Child Study Center, the consultation service of the Grace-New Haven Community Hospital (psychosomatic medicine), the Marriage Consulting Service, the Wethersfield



State Prison Service, or the Department of University Health (Mental Hygiene Division).

Clinical programs in which a considerable portion of the residents' time is devoted to research are encouraged for those who elect a fourth year of training.

Child study

The Yale Child Study Center coordinates all activities within the University having to do with the development and behavior of children. It operates three programs for children: a child psychiatric unit, a child nursery school and a developmental evaluation service.

Research

Yale considers well-balanced research programs essential to a sound

educational program, for learning thrives in the atmosphere of research. Here, where the frontiers of knowledge are being advanced, the student is encouraged to adopt an intelligent attitude toward what is not yet known. The philosophy adopted by the Medical Center is that it is especially important that such an atmosphere be found in a medical center where men and women are being educated to practice medicine and conduct investigation in 1998 as well as in 1958.

An extensive research program is supported by University resources, including endowment designated for that purpose, and by grants from foundations and government agencies.

The Yale Medical Library contains more than 289,000 volumes

throughout the practice of medicine . . .

anxiety

either alone or complicating physical illness

General Practice

Pediatric Psychiatry

Neurology

Gastroenterology

Ob. & Gyn.

Dermatology

The N



Metabolic Disorders

General Surgery

Neuromuscular Disorders

The Neuroses

Allergy

Cardiology



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GRACE-NEW HAVEN COMMUNITY HOSPITAL

CHIEFS OF SERVICE

	UNIVERSITY SERVICE	GENERAL SERVICE
Medicine	Paul B. Beeson	Theodore S. Evans
Ob.—Gyn.	Charles L. Buxton	Joseph A. Fiorito
Pathology	Averill A. Liebow	William B. McAllister
Pediatrics	Milton J. E. Senn	William R. Wilson
Psychiatry	Theodore Lidz	
Radiology	Alfred J. Kummer	Robert M. Lowman
Surgery	Gustaf E. Lindskog	Courtney C. Bishop

CHIEFS OF SPECIALTY SECTIONS, UNIVERSITY SERVICE

Anesthesiology	Nicholas M. Greene
Dental Surgery	William Lawrence, D.D.S.
Dermatology	Aaron B. Lerner
Neurology	Gilbert H. Glaser
Neurosurgery	William J. German
Ophthalmology	R. M. Fasanella
Orthopedic Surgery	Charles O. Bechtol
Otorhinolaryngology	John A. Kirchner
Phys. Med. & Rehab.	Thomas F. Hines
Thoracic Surgery	Gustaf E. Lindskog
Urology	B. M. Harvard, Jr.

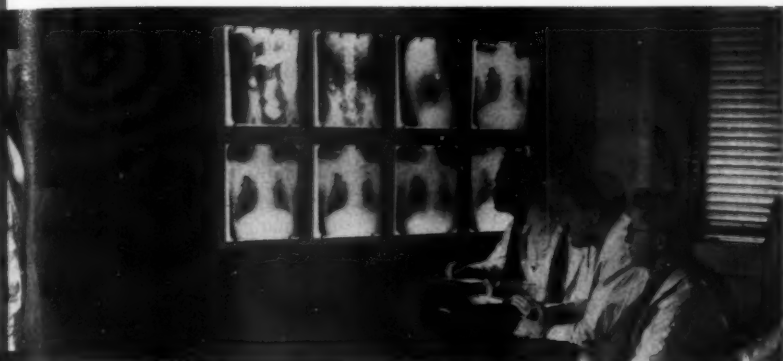
and pamphlets of which about 64,000 are bound periodicals. Some 1,200 periodicals are received regularly. The renowned history library contains several large groups of rare and valuable books, including the collections of the late Dr. Harvey Cushing, the late Dr. Arnold C. Klebs, and Dr. John Fulton.

House staff program

The Grace-New Haven Community Hospital is approved for straight internships in internal medicine,

pathology, pediatrics, surgery and dental surgery. Selection is made on the basis of a formal application, taking into consideration scholastic record and, if possible, a personal interview. All internship appointments are made through the National Intern Matching Program, Inc.

The Hospital is approved for residencies in anesthesiology, internal medicine, obstetrics and gynecology, pathology, pediatrics, psychiatry, radiology, general surgery, thoracic



As a part of their specialty training, residents attend scheduled x-ray conferences.

surgery, neurosurgery, orthopedics, urology, ophthalmology, dermatology, neurology, and physical medicine and rehabilitation.

Residents are selected on the basis of their qualifications, the principal requirement being graduation from a Grade A medical school and one year's internship, preferably straight.

Complete information concerning internship and residency programs may be obtained from the Office of the Assistant Director, Grace-New Haven Community Hospital.

Outpatient

The Hospital operates 67 clinics located within 11 clinical areas. These clinics cover the major specialties of medical practice. More than 300 patients visit these clinics daily. In addition to serving the local community, clinics serve as diagnostic centers for physicians

throughout the southern New England area. Interns and residents have an opportunity to handle clinical problems of all types and to follow these patients through the course of their illness.

The emergency room is unusually active, with about 30,000 visits a year in addition to the outpatient clinic visits.

Living quarters

Each intern and resident is provided with a room in the Hospital's resident staff quarters, with the exception of married members who are provided with an on-call room if they maintain primary residence outside the Hospital. Housing is available in the surrounding community and the Hospital maintains contact with local housing agencies in order to assist interns and residents in finding suitable locations.

Stipends, perquisites

The basic monthly stipend for interns is \$25 a month. To residents the following stipends are paid: 1st year, \$50; 2nd year, \$75; 3rd year, \$100; 4th year, \$125; and senior resident in medicine and surgery, \$200.

Perquisites are given to each resident staff member in the form of room, board, laundry, uniforms, malpractice insurance, free medical care and, where applicable, medical licensure. Cash in lieu of room, board and laundry will be paid as an optional benefit to married interns and residents.

Two to four week vacation periods are offered, the length depending on the individual's service. No difficulty is experienced in placing qualified resident staff wives in good jobs in the Hospital, the University or the community.

Conferences

The regularly scheduled educational conferences are listed. Each service has its regular teaching conferences and rounds. The grand rounds in medicine and surgery and the clinical pathological conferences are usually attended by the majority of the house officers.

Evening lectures and conferences at the School of Medicine are a regular occurrence during the academic year and provide many opportunities to hear distinguished

visiting speakers from this country and abroad. The programs of various study units and the monthly meetings of the Yale Medical Society are also open to interns and residents.

In addition to these activities held at the medical center many cultural opportunities are available on the Weekly Calendar of Yale University in the form of evening lectures and conferences.

Social

As postgraduate students of the Yale School of Medicine, interns and residents are entitled to use the many and superb facilities of Yale University. These include recreation and sports, lecture, concert and cinema series, and the library.

In season, the local Shubert Theatre provides premiere runs of pre-Broadway hits and during the summer months there are several excellent summer theatres including the Stratford Shakespeare Festival. The New Haven Symphony offers an excellent concert series each winter.

The Medical Center is close to Long Island Sound and many fine, conveniently-located beaches are available, while New York is only an hour and a half by train or parkway.

There are a number of dances throughout the year, many informal resident staff parties, and a wives' group which meets regularly.

Clinico-Pathological Conference

Yale-New Haven Medical Center

A 63-YEAR-OLD white female, ill for several years with joint and respiratory symptoms, was admitted to the hospital on April 27, 1957*

PAST HISTORY. Appendectomy; cholecystectomy for cholecystitis and cholelithiasis.

PRESENT ILLNESS. This probably started in 1952 when she was admitted to the hospital because of pain and limitation of motion in the right arm of approximately four months' duration. X-ray examination showed an osteoid osteoma involving the proximal end of the right humerus. She was placed on cortisone and phenobarbital and discharged four days after admission. The pain in the right shoulder continued and localized in the deltoid insertion. It

radiated down the arm and was present constantly. It was aggravated by motion.

An "osteoid osteoma" was not definitely found by the surgeon, however, during a January, 1953, admission when he removed approximately 3 ccm. of bone fragments from the region of the deltoid insertion. The material was interpreted as osteoid osteoma by the pathologist, however. During this admission, the patient complained of long-standing soreness of the second toe on the right foot, and x-ray examination of the

*The editors gratefully acknowledge the cooperation of Dr. Rolf E. Katzenstein, Director of Laboratory, Meriden Hospital, Meriden, Conn., for the material presented in this month's conference.

terminal phalanx showed an "erosion of this structure."

On September 3, 1953 she was readmitted to the hospital for a stay of $3\frac{1}{2}$ weeks. Her chief complaint was pain in the chest, marked hoarseness and difficulty swallowing of at least six weeks' duration, associated with increasing weakness and consequent inability to do her house work. A hacking cough occurred in spasms, both night and day. She also complained of night sweats. Her ears had become swollen and painful.

Examination showed an irregular swelling of the ear lobes with partial disappearance of their regular contours. The swelling had partly obstructed the external meati. There was some erythema and edema of both legs.

X-ray examination of the chest failed to reveal any abnormality of the thorax, the pleura, the diaphragm or great vessels, nor did the barium swallow reveal any change in the esophagus.

While in the hospital, the patient noted stiffness in both legs. Treatment with cortisone and sedation resulted in improvement. After her discharge, she continued to take four tablets of cortisone daily. In spite of this, her ankles became swollen and she experienced severe back pain. The night sweats continued.

During her next admission in November 1953, a systolic murmur was noted in the mitral area and the right chest appeared to be more prominent than the left. However, expansion of the chest was good. The pinnae of the ears now were diffusely red and thickened. There was limitation of motion of the right knee due to pain. There was pain on dorsiflexion of the right ankle and slight "rheumatoid deformity" of the fingers. No contractures were noted. For the $3\frac{1}{2}$ week stay she had daily temperature rises to 101° or 102° which subsided to 100° upon treatment with ACTH. She suffered from a "sore throat" from which at one time beta hemolytic strep was recovered.

Repeated blood cultures were negative; so were the routine agglutinations. No LE cells were found on repeated attempts. Muscle biopsy failed to reveal any lesions.

In spite of the therapy, there was an obvious swelling of her wrist joints. The hacking cough returned and this time it was associated with both inspiratory and expiratory wheezing. Joint pains were eased six days after commencement of ACTH therapy, and two days before discharge, ACTH was discontinued and cortisone was started.

Cartilage change

Cough, sputum, and fever of four days' duration were her chief complaints upon admission in February of 1954. The chronic cough had continued since her last admission. Again, the swelling and deformity of both ear lobes was noted. A peculiar overgrowth of the skin of the pinnae was seen that closed off the external auditory meati. When these overgrown areas were drawn apart, the patient could hear perfectly. The ear drums were intact.

In addition to the ear changes, the dorsum of her nose now had become flattened and the nasal bridge was low with a distinct depression of the cartilage. The finger joints were stiff and the middle knuckles were swollen. There was marked swelling of both knees and ankles with flexion deformity of the left leg.

Under daily doses of cortisone, the patient's condition improved.

A biopsy of the right ear was performed.

Her hacking cough and dyspnea required repeated admission to the hospital. The swelling of the knees, ankles and finger joints persisted. In February 1955, a frank saddle nose and flat ears, painful to palpation, were recorded. The hoarseness was far

advanced at that time and examination of the larynx showed deformity with thickened cartilage and irregularity and nodularity in the arytenoid areas. The glottis was described as narrow.

In October 1955 the joint swelling had become worse; so had the constant barking cough. Wheezing was noted over both lungs, more on expiration than inspiration.

X-ray examination during this admission showed degenerative changes of the trachea resulting in marked narrowing of the lumen of this structure and of the larger bronchi. No abnormality was noted in the sternoclavicular joints. Osteoporosis was noted in the knees, feet and hands. X-rays of the esophagus were normal.

Her respiratory difficulties necessitated an oxygen tent. After a few weeks' treatment with ACTH, potassium iodine, Feosol and penicillin, she was discharged.

During a subsequent hospital admission, her respiratory difficulties, inspiratory and expiratory wheezing, hacking cough, were the most prominent findings and subsided upon ACTH treatment.

Final admission

Her last admission to the hospital took place on April 27, 1956. She stayed until the time of her

Laboratory Data

HEMATOLOGY	HGB.	RBC	WBC	NEUT	STABS	EOS	MYEL	LYMPH	MONOS
11/24/52	12.2		6700	59	6	3		32	
1/5/53		3.49	6500	70	2			27	
9/17/53	10.0	3.26	7200	69	3	3		23	
11/17/53	11.0	3.63	8600	66	3	2		27	
2/24/54	11.3	3.72	11800	67	2	1		30	
5/11/54	11.1	3.51	13400	68	7			25	
2/24/55	9.9	3.31	10700	69	3	1		27	
11/1/55	12.1		9150	69	4			22	
1/24/56	10.7	3.27	9600	45	—	—	—	48	
4/28/56	14.1		9800	63	1	1		31	
4/22/57	9.6		8850	67	1	5		23	

SED RATE	15 MIN.	30 MIN.	45 MIN.	1 HR.
9/17/53	22.5	28	29	30 mm
11/17/53	0.5	2.5	4	6 mm
2/23/54	8	19.5	25	26.5 mm
1/9/56	3	20	22.5	23 mm
8/9/56	10	24.5	26	26.5 mm

BLOOD CHEM	SUGAR	NPN	SODIUM	CHLORIDES	CO ₂
11/11/53	82	33	143.6	98	
2/12/54	96	31		104	66
2/16/54					
5/6/54			147	102	
2/23/55	98	30	144.5	102	
11/1/55			141		
4/28/56	86	34	139	97	
6/26/57			133		

BLOOD CULTURE

11/13/53 No growth on blood agar plate (aerobic) in 3 days
No growth on aerobic broth
No growth on anaerobic broth
No growth on blood agar plate anaerobic CO₂

SEROLOGIC TESTS FOR SYPHILLIS: negative.

MISCELLANEOUS

2/11/55 C-reactive protein—positive 2+.
2/11/55 Test for LE cells—no LE cells found. 10/17/55: same.
2/11/55 Antistreptolysin titer—less than 50 units. 10/11/55: same.

MPH	MONOS	META MYEL	MON EL	BASOPHILS
-----	-------	-----------	--------	-----------

32		1		
27	1	1		
23				
27	2			
30				
25				
27	5			
22	6			1
48	4			
31			3	1
23				

R.	mm	mm	mm	mm	mm
5					
5					

CO ₂	URIC ACID	POTASSIUM
66	1.15	4.31
		4.1
		4.4
		4.42
		4.12

death which occurred on June 30, 1957. Her chief complaint again was shortness of breath and hoarseness.

PHYSICAL EXAMINATION. Blood pressure 120/89, pulse 80, respirations 24, temperature 98.8.

There was considerable deformity of both ears with diffuse swelling and loss of contour with narrowing of the external meati. There was pronounced saddle nose. There was extreme hoarse-

ness of her voice and the extremities showed evidence of "chronic arthritis" with deformity.

During the more than one year's hospital stay her joint complaints varied according to the administration of ACTH and Meticorten. Her respiratory complaints also continued with periods of severe dyspnea and a deep barking cough, alternating with periods of relative well being and reduction in respiratory symptoms.

The medications she received included ACTH, potassium iodide, Aleaire, Neocortef ointment, penicillin, digitalis, Tedral, Pyribenzamine, Cedilanid, ACTH-gel, Hycodan and ACTH zinc, and Penstrep. She became gradually weaker and quietly expired on June 30, 1957.

X-ray findings

1/8/53. Examination of the right foot shows absence of terminal tuft of the distal phalanx of the second digit with flattening of the remaining portion of the distal phalanx on its lateral aspect, suggesting the possibility of a glomus tumor. Examination is otherwise negative.

9/4/53. Conclusion: Normal esophagus. Normal chest.

11/11/53. Examination of both wrists reveals no abnormal bony changes and no evidence of arthri-

tis. Examination of both knees reveals minimal hypertrophic osteoarthritis of both patellae. There are no other bony changes noted. Examination of both ankles reveals minimal hypertrophic osteoarthritis of both ankles and in both os calces.

4/14/54. Examination of the chest reveals no abnormality of the bony thorax, pleura or diaphragm. There is a plaque atelectasis in the right lower lung field and a strand of atelectasis at the left base in the lateral zone. The plaque of atelectasis at the left base may possibly be due to a healing pulmonary infarct.

4/21/54. Re-examination of the chest shows complete clearing of the plaque of atelectasis at the left base. The left lung field is clear. The strand of atelectasis at the right base also shows a partial clearing. The remaining lung fields are clear.

4/30/54. Re-examination of the chest shows complete clearing of the strands of atelectasis at the right base. There has been further clearing of the small patch of atelectasis at the left base. The remaining lung fields are clear. There has been a considerable improvement in the appearance of the lung fields since the last examination of 4/21/54.

2/12/55 Metastatic series—examination of the chest reveals no abnormality XXXX. Examination of both knees shows a moderate demineralization of the bones of both knees. Examination of the nasal bones reveals no abnormality. There are no abnormalities noted in any of the nasal cartilages. Examination of the cervical spine (L. view) reveals no abnormalities except minimal osteoarthritis of the lower half of the cervical spine. Examination of both hands reveals an advanced osteoporosis of the bones of the hands with pseudocystic degeneration noted in some of the phalanges and carpal bones. Examination of both feet reveals a moderately advanced osteoporosis of all of the bones of the feet. Examination of both auricles reveals calcification in the cartilage of the left ear.

10/10/55. Examination of the sternoclavicular joints and sternum shows no abnormality. Examination of the knees, feet and hands by means of survey films shows marked osteoporosis throughout the region examined. There is no definite evidence of cartilage absorption involving the joints. The examination is otherwise negative.

10/12/55. Barium swallow—

conclusion: normal esophagus.

5/20/57. Conclusion: No evidence of active disease in the chest.

Discussion

Discussion by Dr. Gerald Klat-skin, Professor of Medicine, Yale University School of Medicine and Associate Physician, Grace-New Haven Community Hospital.

This patient succumbed to a five year illness characterized by a) constitutional symptoms of weight loss, fever, sweats and weakness, b) a severe disabling arthritis, c) progressive hoarseness, cough and dyspnea, and d) destructive lesions involving the cartilages of the ears, nose, larynx and bronchi.

The distribution of the joint involvement, the deformity of the fingers and the accompanying osteoporosis suggest the possibility of rheumatoid arthritis. However, the absence of typical narrowing of the joint spaces in the face of progressive disability over a five year period makes it unlikely that rheumatoid arthritis was the underlying disease in this case or a complication thereof.

Respiratory findings

Cough and dyspnea were outstanding symptoms from the very

beginning, and respiratory failure was the ultimate cause of death. The barking character of the cough, the associated wheezing and dyspnea, the absence of pulmonary findings, other than disc atelectasis on one occasion, the relative paucity of sputum and the subsequent demonstration of narrowing of the larynx, trachea and bronchi suggest that the respiratory symptoms were due to obstruction of the major airways rather than to pulmonary or cardiac disease.

By far the most striking and unusual feature in this case was the widespread destruction of cartilage which resulted in distortion of the ears, the development of a saddle nose and deformity and narrowing of the larynx, trachea and bronchi.

In addition, similar involvement of the costal cartilages may have been responsible for the otherwise unexplained chest pain noted in the history. Conceivably the joint cartilages too were involved despite the absence of confirmatory radiographic evidence.

Of particular note is the fact that no mention is made in the protocol of mucosal ulceration in the nose or larynx, or of nasal discharge, mucosal bleeding or significant sputum.

This suggests that the destruc-

tion of cartilage was not secondary to disease of the mucous membranes, and thus tends to rule out a number of granulomatous diseases that affect the respiratory tract cartilages, such as tuberculosis, syphilis, midline lethal granuloma, and Wegner's granuloma.

Supporting evidence

Further evidence in support of this conclusion includes:

- The involvement of the auricular cartilages which is not known to occur in any of these diseases.
- The presence of a chronic rheumatoid-like arthritis and the absence of pulmonary lesions in the case of tuberculosis.
- The severity of the constitutional symptoms, the fatal outcome, the presence of arthritis and the negative serology in the case of syphilis.
- The absence of destructive lesions involving the face in the case of midline lethal granuloma.
- The relatively long course and the absence of renal or pulmonary findings in the case of Wegner's granulomatosis.

Collagen disease

The prolonged fever and arthritis raise the question of whether or not the cartilaginous changes

could have been secondary to one of the generalized collagen diseases involving either the perichondrium or its blood vessels. This appears unlikely, but is worthy of consideration.

The chest pain, cough, edema, the mitral systolic murmur and the skin changes over the ears suggest the possibility of disseminated lupus erythematosus, but the negative LE tests and the absence of renal or serosal involvement would appear to rule it out.

Scleroderma comes to mind because of the dysphagia, the history of a painful toe that was accompanied by the loss of the tuft of its distal phalanx, the swelling followed by flattening and calcification of the ears and the occurrence of contractures.

However, no sclerodermatous changes were observed in the esophagus radiologically; no mention is made of thickening or induration of the skin, except over the ears; the calcification was localized in the cartilage and not in the subcutaneous tissues of the ear, and finally, the severe constitutional symptoms and fatal outcome are not consistent with this diagnosis.

Dermatomyositis is suggested by the muscular stiffness, weakness and contractures, the diffi-

culty in swallowing and the erythema and edema involving the legs and the ears, but would appear to be adequately excluded by the absence of muscle induration and the negative muscle biopsy.

Periarthritis nodosa could conceivably have produced some of the manifestations seen in this patient, but the absence of hypertension, evidence of renal involvement, abdominal pain, or neuropathy rule it out.

Cartilage affected

By exclusion we are forced to conclude that the underlying disease, whatever its nature, affected the cartilages of the body directly.

Ochronosis, one of the diseases known to do so, can be eliminated from consideration for a number of reasons:

- While the deposition of pigment in the joint cartilages results in their degeneration and destruction leading to a characteristic type of arthritis, the deposition of pigment in the other cartilages of the body has no destructive effect.
- The disease is unattended by the severe constitutional symptoms noted in this patient.
- There is no mention in the protocol of the urine containing any unusual pigment or reducing substance to suggest the presence of homogentisic acid.

● The photographs of the patient show no unusual pigmentation of the ears or nose.

● The x-rays of the spine do not show the characteristic narrowing and calcification of the intervertebral discs seen in ochronosis.

Rare entity

Finally, we come to the one disease of cartilage that can best explain all the clinical features in this case, a rare entity first described in 1936 by von Meyenburg and Altherr as generalized chondromalacia. To the best of my knowledge only four other cases have been reported since then.

Clinically the disease is characterized by a rheumatoid-like arthritis, evidence of progressive softening and destruction of the cartilages of the nose, ears, larynx, trachea, bronchi, ribs and joints, and constitutional symptoms. Respiratory difficulty due to laryngeal involvement has been particularly severe in all cases, necessitating tracheotomy in at least four.

Saddle nose has been a regular finding, and in most cases the ears have been deformed.

As in the present case, the arthritis has usually been associated with marked osteoporosis and normal joint spaces. However, in



In this profile view, note the saddle nose and deformity of the ears.

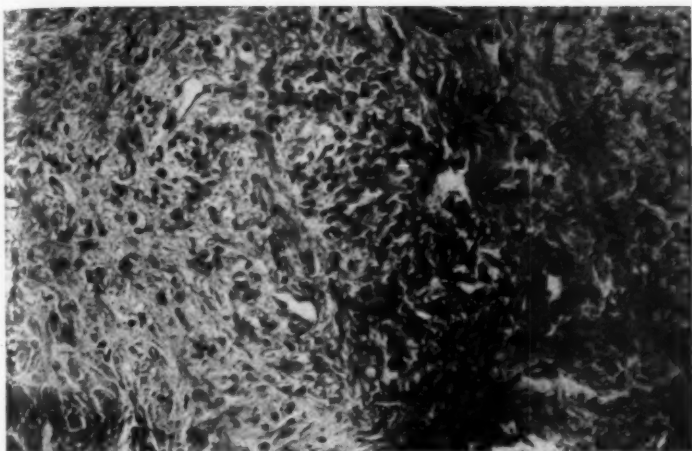
a few instances the radiological signs have been characteristic of rheumatoid arthritis. In one instance calcification of the ears proved to be due to new bone formation. One feature seen rather frequently, that was not present in the case under discussion, is iridocyclitis and episcleritis.

Gross examination at autopsy reveals destruction, softening, thickening and deformity of all the cartilages with narrowing of airways, loss of nasal cartilages, depression of sternum due to collapse of the costal cartilages.

Histologically the cartilage shows:

- Loss of glycoprotein in its ground substance revealing the underlying reticulum fibers.
- Early invasion of highly vascular connective tissue.
- The latter appearance of an inflammatory reaction and fibrosis involving both the cartilage and its perichondrium.
- Necrosis and degeneration of the cartilage and its chondrocytes.
- Islands of new cartilage and bone formation.

Nothing is known about the



Acute inflammatory reaction associated with necrosis of cartilage.

etiology of this disease, but there can be little doubt that it represents a distinct clinical and pathological entity unrelated to any previously described rheumatic state or disorder of cartilage.

FINAL DIAGNOSIS. Generalized chondromalacia (von Meyenburg's disease) with involvement of the cartilages of the ears, nose, larynx, trachea, bronchi, and probably the joints and ribs. Death was due to progressive respiratory failure secondary to obstruction of the trachea, larynx and bronchi.

Pathology

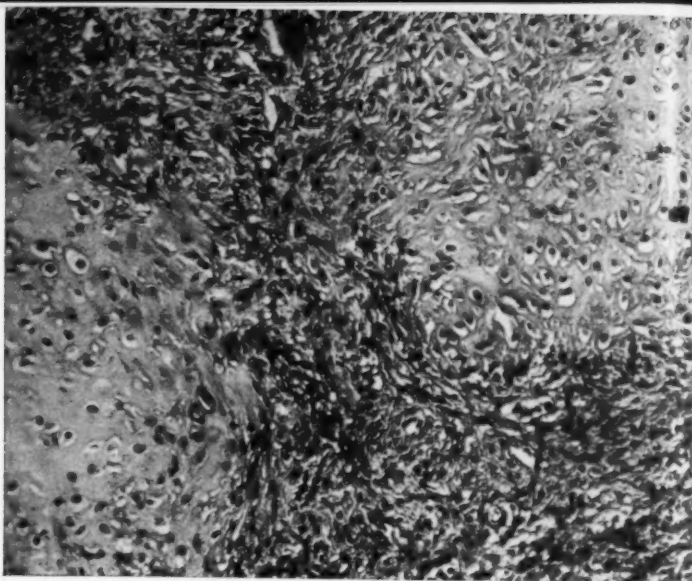
Discussion of the pathological findings by Dr. Rolf E. Katzen-

stein, Associate Clinical Professor of Pathology, Yale University, School of Medicine and Director of Laboratory, Meriden Hospital, Meriden, Connecticut.

Dr. Klatskin has correctly classified this patient's illness as "systemic chondromalacia." The clinical course and autopsy findings coincide with those found in the previously described four cases. (See Ref.)

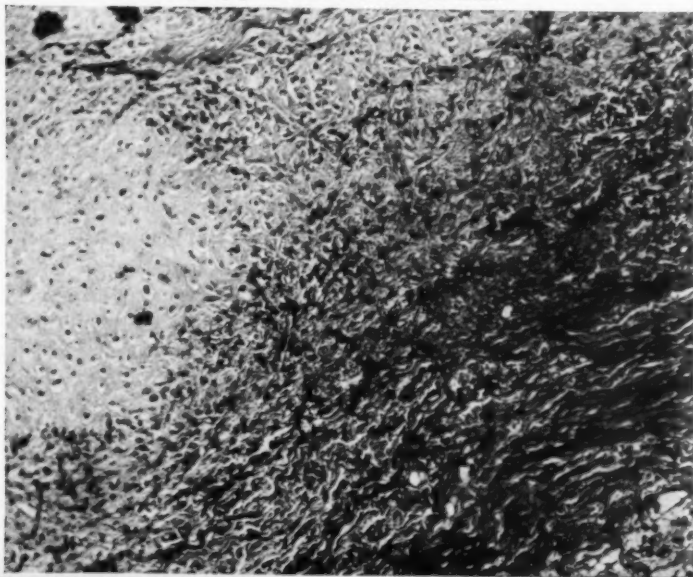
The first slides you will see are illustrations of the ear and the nose which show the typical "cauliflower" appearance of the ears and the "saddle" appearance of the nose.

The next slides illustrate the



Invasion of previously destroyed cartilage by granulation tissue.

Replacement of cartilage by granulation tissue and scar tissue.



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Aug

essential microscopic pathology as it was found on the biopsy of the ear: Destruction of cartilage with extensive chronic inflammatory and partly granulomatous reaction. A marked amount of granulation tissue has replaced the destroyed cartilage. This represents the acute or recurring acute and organizing phase of the disease.

Important findings

The important gross autopsy findings were essentially those in the small joints, the respiratory system, and the ears. There was most severe "arthritic" deformity of the small joints of the hands and feet with marked edema around these structures, and caving in of the sternum at the sterno-clavicular joints. No examination of the small joints was performed.

The thorax was barrel-shaped and the lungs emphysematous. The larynx showed diffuse edema and deformity with narrowing of its lumen. The trachea had been changed into a flabby tube that was partly collapsed and its lumen was reduced to an estimated half of its diameter. Its wall showed considerable thickening and the cartilaginous rings of these structures could not be felt or seen grossly.

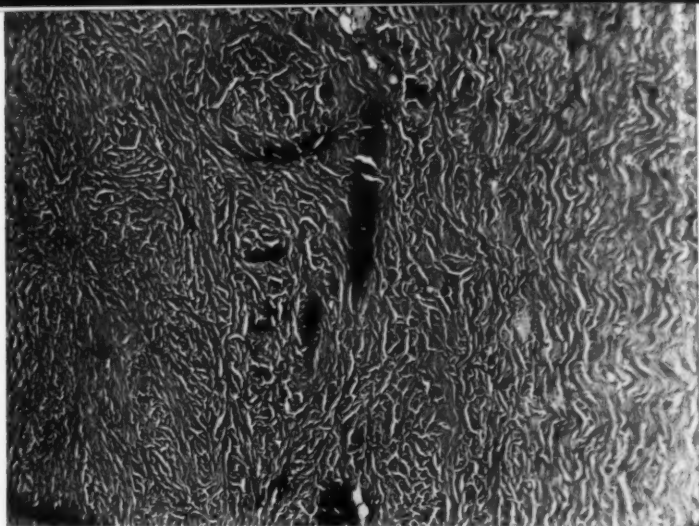
The same change had involved

the main bronchi to both lungs as well as the bronchi of the second order. Both lungs showed a considerable amount of diffuse emphysema. The smallest bronchi and bronchioli were occluded by a muco-purulent exudate.

Microscopic examination

The microscopic examination of the larynx, trachea, bronchi and bronchioli showed the final state of the acute changes seen in the biopsy. Thus, cartilage had been completely or partly replaced by thick layers of hyalinized connective tissue which, in the trachea, had resulted in its complete disappearance. In the bronchial walls, only part of the cartilage had been replaced by scar tissue and there were occasional foci where obviously regenerated newly formed cartilage was noted.

In addition, inflammatory lesions accompanying necrosis of cartilage were noted of the same nature as seen in the biopsy. This finding confirms Harder & Krauspe's statements that we are dealing with a recurring acute attack of necrosis of cartilage. The acute state is followed by granulation and scar tissue formation. The end result is a softening of the tracheo-bronchial wall and narrowing of the lumina of these



Scar tissue replacing cartilage.

structures, which in turn produces a marked degree of emphysema. The immediate cause of death was an acute necrotizing bronchiolitis.

An additional finding was the presence of sarcoid reaction in both lungs and lymph nodes in which no tubercle bacilli were demonstrable.

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Vernon W. Lippard, M.D.



Guest Editorial

Opportunities in Academic Medicine

THERE HAS NEVER BEEN a time when opportunities for careers in academic medicine have been as great as they are today. The expanding population of the United States will require the services of additional physicians at such a rate that the number graduating from our medical schools annually should be increased by 2000 within the next 20 years. Unless existing schools expand to a greater extent than seems at all likely, new schools will have to be established at the rate of one a year over that period.

Support for medical research is increasing at a similar pace. Even in terms of 1940 dollars, there has been a threefold expansion over the past 15 years.

Paralleling the growing demand for teachers and research scientists for medical faculties is recognition of the fact that the full-time physician must be compensated more adequately. The difference between faculty salaries and income from private practice is diminishing gradually. When income taxes and fringe benefits such as annuities are taken into consideration, the differential is smaller than is generally realized.

With these facts before him, the young man in training today, at either the medical student, intern or resident level, should give serious thought to the possibility of a career in teaching and research. For those whose interests lie in the basic medical sciences, opportunity to participate in the advancement of knowledge of human biology should be attractive. In many medical schools, transfer from the standard medical curriculum to a program leading to the Ph.D. degree in the basic sciences can be arranged. For those who decide to complete the course leading to the M.D. degree before concentrating in one of the basic sciences, postdoctoral fellowships are readily available.



VERNON W.
LIPPARD, M.D.
Dean,
School of Medicine,
Yale University

Similar opportunities are open to the young physician who plans to enter the faculty of a clinical department. For a career in this area, a good residency in a university hospital is essential. Concentration on clinical experience alone during this period is, however, unnecessary. Many residencies provide for an assignment of several months in the laboratory, and for the man who is so inclined, participation in a research program is usually encouraged.

Postdoctoral fellowships, many of which provide quite generous stipends, can be obtained to cover living expenses for a man and his family during a year in which residency training is interrupted.

For many, this is the year of decision and the man who is wavering between the choice of academic medicine and practice will find this experience a good investment. Relieved of the pressure of heavy clinical

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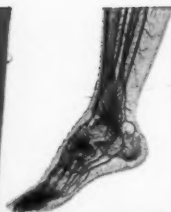
EATON LABORATORIES, NORWICH, NEW YORK

responsibilities, he can get an idea of what an academic career is like without making a firm commitment. If he decides to enter practice, he will be a better physician, so the time is not wasted.

Every medical student, intern and resident in the current generation should consider seriously such an opportunity. For the man whose interests lie in that direction, a career in academic medicine offers a rich and rewarding experience. The channels are open as they have never been before.



"... Fornasan complicated with a little crintz, nothing really serious, but we must be sure it doesn't develop into kanafan, absolutely no candy, cake and malteds for a week or we may have to anaferon with the brivin..."



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My First Year in Obstetrical Practice

Getting properly located in private practice requires planning.

At least, that's my conclusion after going through the experience. And the planning should definitely begin early in residency.

Before I finished my second year, I had decided that I was going to practice in a suburb near where I was born. Both my wife and I are city people, born and bred. Yet, we wanted a suburban type of living. My wife had ideas, persistent and frequently expressed, of coming out to a suburb with an adequate school system, in an area away from crowded city living.

Because of an illness in my family, we weren't able to get out and make field trips until about two months before the completion of my residency.

Ellis J. Morgan, M.D.

This could be titled "The Long Wait." The author sweated out a rough first year in a suburban location before he finally got his practice off the ground.





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The dosage is 25 to 50 mg. daily for adults. For children the daily dosage is 1 mg. per kilogram of body weight; this dosage should be reduced to 0.5 mg. daily if given to prepuberal children for more than ten days.

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Personal report on a private practice

But in the two months, we spent every spare moment traveling over the country of our choice, speaking to physicians, getting an idea of the physician-patient ratio within my specialty.

Estimating the number of people in the area, not just in the town but in the drawing area, and determining the number of obstetrician-gynecologists in practice was project number one. This was done in informal talks with obstetrician-gynecologists as well as doctors in allied specialties.

To get acquainted with OB men in the area before we located was simply a matter of calling them on the phone and then going to see them. For the most part, they were friendly. I explained to them what I wanted to do; about half of them said "go elsewhere." The others said "come on out; you'll make a fine living here, there's always room for more."

I couldn't help but think of the rich discussion which would result if ever these two diverse camps were brought together.

Of course, the doctors on the staff of my residency hospital gave me encouragement in a general way.

Most of them told me they were

losing more and more of their patients to the surrounding suburban areas and that as far as they were concerned the probability of my practice building up within a reasonable time appeared to be very good.

These physicians, however, were not completely familiar with conditions existing in a suburban practice. They were guessing—only with more experience than I had.

Error

My own guesswork proved to be in error; the doctor-patient ratio was not as I had anticipated beforehand. Not only that, but soon after I hung out my shingle, two other men



opened in the same area. So, what before may have been a very comfortable ratio promptly became a little overcrowded with OB men.

I also miscalculated, failing to consider the number of obstetricians



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within commuting distance from my locality. However, another factor balanced this out. I wasn't aware that patients would come to me from outside my area, not just in my town. Referrals to a specialist evidently come from a much wider area than I had anticipated; my drawing area is larger than I had thought. This condition sort of compensated for the extra OB men who came in.

In inquiring about a location I spoke to a few pharmacists. Most seemed to feel that any professional man coming into the town would do well. I don't know whether this is because, if a doctor comes into town and does well, they want to be able to say I told you so. Perhaps they don't want to antagonize a doctor. The thought: "If I told him not to come but he came and he made out well anyway, he's not going to like me and he's not going to send me any work."

So, to some extent, I took the pharmacists' opinions with a liberal sprinkling of salt.

Opinion

Similarly, a layman's opinion is not too valuable. For example, one man told me: "If my wife had known there was a gynecologist in the area, she would not travel into the city to see her gynecologist there." This is ridiculous because between our suburb and the city there are any number of competent men. The lay person isn't fully aware of the professional population, even in his own

area. Also suburbs are new and fast-growing. It's hard to keep up with the rate of growth in places such as the peninsula south of San Francisco or the whole of Long Island in New York. I have friends who have been in my suburb for six years and yet until I told them, didn't know of many professional people, both general practitioners and specialists, in their immediate vicinity. This is quite normal. Obviously I'm more concerned about total physician population than is any layman in a community.

Minutes

I found public transportation facilities in the suburbs a relatively unimportant consideration in locating. Patients cannot get to my office by taking a train or a bus. They are either within walking distance or they take an automobile. If they take an automobile, five or ten minutes is not going to make much difference. Some patients drive 20 or 25 minutes to my office. Actually, people in a city ride for longer periods than this by bus or subway to get to an obstetrician's office.

Actually, I thought patients wanted to be very near their obstetrician's office. Surprisingly, this was not the fact. Some want to be close to their pediatrician or they want to be close to their general practitioner but they feel no need for the surgical specialist to be close at hand.

Because of the brief time we had available to find a location and also

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because of the fact that we didn't want to invest heavily in a house at the beginning, we decided on the renting of both a house and a separate office.

This arrangement was not the most economical. I realized later that the rental I paid on an office could easily have been applied to a home mortgage. For example, with a separate office and home I am now paying \$70 for an office and \$95 a month for my home.

By combining both payments and adding perhaps \$20 more a month, I could have a house twice the size of the one I now have, located in a nicer area and with the convenience of my office in the same building.

Also important is the fact that any improvements to the house can be deducted, in part, as office expense.

Of course, the most obvious advantages of having a house and office all your own is that you can see patients at any time and, my wife is at hand to step in and help, if needed.

This would have relieved me for a time of the extra expense of hiring a nurse while my wife sat at home with the kids.

Of course, I can see all this now but it wasn't obvious to me when we first started looking for an office location.

Share an office

While we were checking on an old professional building in our future

area of practice, we met a physician then in practice in the town. He asked me where I was planning to locate. I told him I was looking around and hadn't quite made up my mind but thought I would rent space. He thereupon made me an offer of space in his office. He was a pediatrician—and as it turned out, he had a tremendous practice.

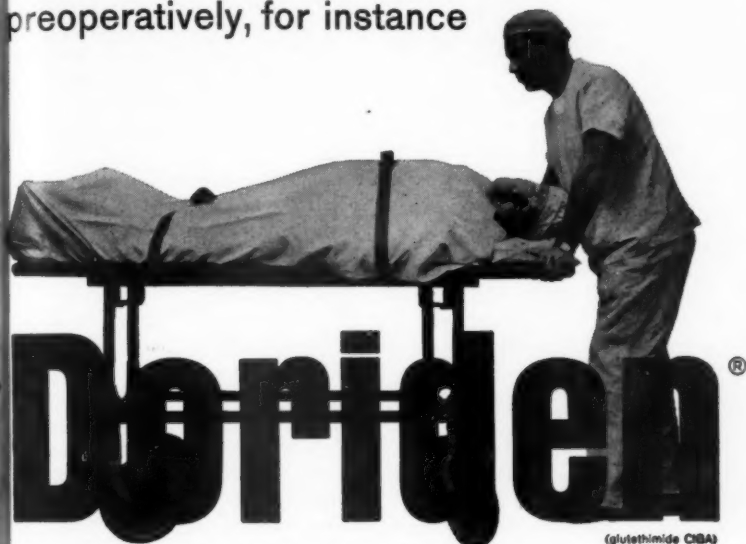
Temporarily, our problems appeared to have a ready solution. We put down the first month's rent on a house in the area. Then I moved what little equipment I had into the pediatrician's office space. I paid him a monthly rent, but initially I had to put up a little money for some equipment that I did not have and was not available in the office.

Hours

At first there were no evenings available although that situation was corrected later on. I had three sessions a week for \$60 a month. I started out with Tuesday and Thursday afternoons and, believe it or not, Sunday morning. I thought certainly that Saturday would be preferable to Sunday, however, when I was in a position to give up my Sunday work many patients pleaded with me not to change because it was so much more convenient for them. It seems that they would be able to come with their husbands and children and not have to worry about baby sitters.

Saturday offers the same opportunity but the suburban husbands

Less restricted* sedation . . .
preoperatively, for instance



(glutethimide CIBA)

"One hour prior to surgery, twenty-five patients were given one-half to one gram of Doriden. Ten of the twenty-five patients slept on the stretcher while waiting to be wheeled into the operating room. . . . the remaining patients seemed to have the calm indifference that is found in partially narcotized patients. There was no respiratory depression. The drug provided very satisfactory preoperative sedation."¹

*SEDATION WITH DORIDEN IS LESS RESTRICTED because, unlike barbiturates, it is not contraindicated where renal and hepatic disorders are present; unlike many barbiturates, Doriden rarely causes pre-excitation; unlike barbiturates traditionally used for sedation, Doriden is metabolized quickly, thus rarely produces "hangover" and "fog."

SUPPLIED: TABLETS, 0.125 Gm., 0.25 Gm. and 0.5 Gm.

1. Matlin, E.: M. Times 84:68 (Jan.) 1956.

C I B A
SUMMIT, N. J.

are busy working around the yard, mowing the lawn or taking the kids to a ball game.

Of course, for my own convenience I would like to have weekends free. As soon as I can, I will switch to evening hours a few nights a week



and transfer all my Sunday patients to these hours. I think they would go along with that, and I'm certain I would prefer it.

Nurse

An important part of obstetrical practice is the nurse. I was fortunate in this regard and was able to arrange with a local woman who was an RN and a housewife. She agreed to come to the office when I needed her and I only pay her for the days she comes in.

Ordinarily, I suppose, it would be difficult to find a nurse who would work on such a flexible schedule, but she has two children of her own, prefers to spend most of her time at home anyway, and

has all but given up nursing. I can call her the night before or even the morning of an appointment and she will put on her uniform and come over to the office, staying for as long as I need her.

There were some drawbacks. First of all she had no previous office experience. Although she doesn't know how to type, she can answer the phone when I'm busy, do minor laboratory procedures, weigh patients and assist me during some therapy.

Patients

I finished my residency January 1 and officially opened my office January 15. Prior to opening, I hadn't achieved any major hospital affiliations, that is, with any of the voluntary hospitals. I was free to use any of three proprietary hospitals in the area.

Before opening day came, what would have been my very first obstetrical patient, referred to me by the pediatrician whose office I was subleasing, telephoned me to cancel her appointment. She stated that she merely had a delayed menses and was now menstruating. She sounded relieved. I felt awful. Where before I was in a period of great elation, this news caused me to descend into a period of depression.

During the first week of office hours, the phone rang constantly. All calls, however, were from well-wishers, family and friends; all wanted to know how many patients

I had seen, what had happened so far. Each time the phone rang, I waited two rings, which was to indicate some degree of occupation, picked up the phone and gave out with a "Hello, Dr. Morgan speaking."

Each time, the reply would be a happy "hello!" From a friend; not a patient.

Gradually the phone calls from well-wishers decreased in number. Soon, the silence seemed worse than when the phone was ringing. Now there was nothing to do but sit and wonder about what was going to happen with this embryo practice of mine.

I became acquainted with various popular lay magazines.

For some reason, medical journals and journals relating to my specialty didn't hold quite the interest they once did when I was still in residency preparing for the cold, cold world of private practice.

One night about a week after opening the office I got a call from telephone service: a patient wanted to make an appointment. It was an "emergency" and "could she see me quickly." I called the patient, my first private patient, and arranged to see her the next morning. I saw the patient, examined her for a minor Gyn complaint, treated her and sent her home.

That same evening I got a call from the patient stating that she had a temperature of 104 and would I please come and see her.

I immediately began to think of all the terrible things that might have gone wrong, all the things I might have missed. My diagnosis in the office had been chronic inflammatory disease. That evening when I re-examined her, I found nothing beyond what I had discovered in the morning examination. Then, in an effort to be completely honest, I told her that it's not infrequent that after an examination, in cases of an inflammatory disease, the temperature will become elevated.

The patient may or may not have been content with my explanation, but one thing is certain: I never saw her again.

On my way home, it suddenly occurred to me that this honest explanation was not the better part of valor. I was angry at myself for having implied to the patient that my examination was the cause of her feeling so miserable that evening. Yet, at the end of the month I submitted my bill, \$18 covering home and office visits, and was promptly paid by the patient.

My second patient was one of the nonpaying kind. Referred to me by my junior resident, the patient was the wife of a surgical resident. This was my first actual private obstetrical case. When she came into the office, even though I knew that there was no fee associated, I was very happy. Here was my first OB; I was doing something I had been trained to do. I felt suddenly as if I had become of use to mankind.

This was three weeks after finishing my residency.

Early months

The next few months saw a few ups and many downs. The greater proportion of my rather infrequent patient load in the early months consisted of the maids of various well-to-do people in my area. They were brought in for physical examinations prior to employment to make sure they were healthy and free of venereal disease. I began to feel that I was becoming known as the "maid doctor" of the town.

Gradually, from outside sources, a number of obstetric referrals developed. I remember one in particular, the wife of a school principal who came in during June to be examined. She was pregnant. She immediately left for vacation. When she returned in the fall she told me that she had had a miscarriage during July.

Another early patient was a woman who lived in the apartment project where my office was located. She came to me, was pronounced pregnant and after two months, moved to California. It seemed I was never to get a patient to term.

I can think of another patient who came to me pregnant; her husband had died two and a half years previously; she wanted a surgical abortion. I told her I couldn't help her.

There were many who came, greatly fearing they were pregnant



but who were actually just a few days late.

To understate the case, I never imagined that this constituted the practice of obstetrics as I viewed it from my position as a resident. After each week of such visits I would try to assure myself that this was extremely unusual. Then, I began to worry that this might be fairly common.

In three months, I saw only three bonafide obstetrical patients who continued through to delivery, one of whom was the doctor's wife. I seriously began to doubt the prospects of the area I had selected.

Fortunately—and I emphasize this point—we did have some financial backing to tide us over a long period. Yet, I didn't want to expend it all and then conclude that the area was not going to support an obstetrician. This feeling of anxiety was not helped by the fact that I learned in the early weeks that another obstetrician was opening in

my suburb and still another planned to open in the summer. Unexpected competition, not so much the competition then in the town, but additional men, was disturbing.

Total

During my second six-month period of practice, the number of obstetrical patients picked up; by the end of my first year of practice I had achieved a grand total of eleven OB cases.

Although this was a fair number for the first year, I was discouraged by the fact that referrals were no more frequent at the end of the first year than they had been in the first six months of practice. There was no gradual increase at the end of the year that might portend increased volume in the second year.

In the mixture of events without pattern which occurred to me, one incident stands out in my mind. One dark, rainy night, after I had gone to bed, the phone rang; an obviously uneducated male voice urged me to "come, please . . . right away!"

The address was in the most decrepit, slum area in the entire county. I hedged a bit, asked him who had referred him to me. He said he had gotten my name out of the phone book.

The nature of the complaint was that his wife had severe "pains in her belly."

It might be a fake call, I thought, immediately conjuring up a picture

of a dark hallway, a desperate narcotic addict — my imagination compounded my fears.

Police

I called the police and explained to them that I had received an unreferred call in this particular section of town and though it might be a legitimate call it might also be a call in which its main purpose was the narcotics in my bag.

I asked the police if they would please trail me to the call, wait until I came out, and if I did not come out within five minutes, "come and get me."

As it turned out, as soon as I entered the house, I saw it was a legitimate call. To the utter confusion of the patient and her husband, I walked to the window and waved, calling off the police. I then attended the woman who had had a spontaneous complete abortion.

As a result of my responding to this call, I was referred two obstetrical cases and one Gyn case by this grateful patient.

Including minor gynecological office procedures and examinations, the results of my first year of practice were hardly outstanding.

Yet, I continued to receive enthusiastic encouragement from physician friends who preceded me into private practice. In substance, they assured me that this was not an unusual picture, one which I could have expected, and to look forward to a future which could only be

"better and brighter."

Unfortunately for me, and I suppose for most Ob-Gyn residents, this first year of suburban practice is never painted accurately enough for you to consider it a normal or fairly normal thing to have a poor year financially.

Long process

In the last two weeks of the first year plus the entire first month of the second year there were no new patients. But the silver lining finally peeked through in the second week of February. Suddenly, I had three new obstetrical patients.

And ever since February, I have had an average of one new patient a week!

Evidently the time spent socializing, mixing with colleagues and just being available in the first year began to show results.

Building a practice is a long process. This had been told to me many, many times by doctors during my training. But somehow sitting around your new office waiting, you just can't feel calm and collected.

You don't know who's talking about you, who hasn't heard of you, who had heard of you; it doesn't seem quite real. Yet, it just takes patience and time, lots of it.

I still have the opportunity and time to read. But now, with the beginnings of a good practice already established, I am much more interested in the journals, in the conferences at the hospital, in keeping up

with the advances in my specialty.

One thing I have neglected to mention, although chronologically it comes during that first year, is hospital affiliation. Since I am in a surgical specialty, hospital affiliation is extremely important. Every patient coming into my office is a prospective hospital patient.

The fact that my hospital affiliation was not arranged in the early weeks of my practice did have something to do with the slow build-up of my practice. Not having hospital affiliation inhibited my meeting and getting to know other doctors who were in a position of referral.

During the first year I applied to three voluntary hospitals in the area. I was put off by one and eventually accepted by the second and third. But these acceptances did not come through until after almost a year in practice. Although none of them said I would have to wait a year, somehow "the committee didn't meet" or "credentials" weren't "approved." And time went on and on.

The first hospital, which had told me to wait awhile, also notified me that I was living outside of the preferred area. I later checked and found this to be a recently enacted policy; there were men on the staff who had been accepted prior to limiting the area.

An understanding

The second hospital told me that they had become over-staffed, had 29 obstetricians for a total of 32

obstetrical beds, and that they would not put on anybody else until they increased their bed facilities.

This situation is not uncommon in a rapidly growing suburb. I also found something of a paradox. The chief of Ob-Gyn at one hospital said, "wait until you open your office and then come back. We won't consider you for appointment until after you have an office."

If you have picked the chief of service where you took your training because of his stature, and if he is sufficiently impressed and interested in you, it is possible that you may establish an unwritten understanding prior to opening in a specific area, which assures you of an appointment. This is desirable but not always possible of attainment.

The third hospital in my area is a new building. A good number of its obstetrical beds were empty and the administration was eager to take on men so as to increase patient load; as a result I was able to obtain an appointment there. Soon after my affiliation, the hospital became very tight; few obstetricians can get in now.

Over again

Looking back on it, I would have liked to have been able to devote more time to investigating my choice of location.

First, I would have found out beforehand more about the physicians in town and in the surrounding areas.

Secondly, I think that I would have begun with an office in my home.

Finally, I would have liked to have had more of an "in" through my residency chief concerning hospital appointments. While this may not have been possible in my area, I might not have chosen the area knowing that an active practice in my specialty cannot exist without at least one hospital connection.

A new man coming in at this time might have an even more difficult time than I had. There are areas, I am sure, where hospitals have more staff openings.

If I had to do it over, knowing as I do now that my practice is going well, I would be safe in saying that I would locate in the same place, providing my hospital appointments were secure. But if this question had been put to me a few months ago, before the sudden spurt in my practice, I might have said: "No. I would certainly go where there is a real need for new men. I think that an OB man coming into this area now could make a living — but it would take longer than average to get established."

There are many areas outside of cities where doctors are needed and would probably do well more quickly. But the main thing that you're looking for is a successful practice.

You've got a wife and you've got a family. You could be happy most any place you go because you've got your work; you're interested, you've

got your associates, you know what you're doing and you can do it well. Yet your family might like different things or want certain things available. They may want a big house, pleasant climate and living area, perhaps theatre, the arts, a museum, exceptional educational facilities for the children. All of these are the factors you must consider in addition to the economic potential of your practice.

You're earning a living but, also want to enjoy life. And you're not going to enjoy life where there are inadequate facilities, according to you or your wife's ideas.

Unfortunately, it is difficult to find any areas with many patients, few doctors, excellent facilities, and equable climate.

If you like the hot, humid weather of the South you could find some good possibilities down there.

If you like cold weather you could go up North; I'm sure you could do well in the Dakotas, for example. But if you like your living with suburban benefits, as I do, then a location such as mine is more suitable—but more difficult.

If you've got family problems which hold you to one area then you are necessarily limited.

Hospitals

At the present time I am associated with two hospitals in my immediate area. At both of these hospitals I have courtesy appointments. After a period of a year with a

courtesy appointment, I will be placed on staff at which time I will have an active part in resident and intern teaching and research.

The third major hospital appointment I have is at the hospital where I took my training; it is a good hour away.

I am already engaged in resident and intern teaching at this hospital, and this stimulation is important. When you're in residency you're in the hospital. You practice not just 40 hours every week but all day every day, and every other night as well.

You live with medicine and in an atmosphere of learning.

In private practice you're not at the hospital all the time. Your stimulation must be achieved at hospital conferences, rounds, journal clubs, and social meetings with other physicians.

To neglect this phase of practice is, I believe, to rob yourself of a most vital experience.

Coverage

As far as coverage is concerned I did cover another man who went on vacation—this was after I got the appointment at the hospital where he was on staff.

As far as coverage for my own practice; because my work was so scattered among available private hospitals, if I wanted to go away, there was no one man whom I could call to cover me. As a result I felt that I couldn't go.

Now that I have two major hos-

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- one injection sufficient in 80% of cases³
- itching abates promptly⁴
- most reactions clear in 12 to 96 hours^{2,3}
- well tolerated¹⁻³
- may be lifesaving in certain anaphylactic reactions^{4,5†}

[†]For this reason, and from these studies, penicillinase [NEUTRAPEN] should be kept on hand in every doctor's office or hospital where penicillin is administered.^{6†}

NEUTRAPEN aborts penicillin reactions by catalyzing the hydrolysis of penicillin to penicilloic acid, which is non-allergenic. Current therapy—antihistamines, ACTH or steroids—treats effects. NEUTRAPEN counteracts the cause. It inactivates circulating penicillin within an hour after injection, and continues to act for four to seven days.^{1,2}

NEUTRAPEN acts rapidly—80% get complete clearing within 12 to 96 hours after a single injection, over 95% with two injections.⁴ In an earlier study, Zimmerman³ reported prompt and complete clearing of reactions in 45 of 52 cases. Becker^{2,3} noted complete clearing of urticaria and angioedema within 24 to 72 hours in 42 of his 46 patients. The absence of relapses was termed "a major clinical achievement..."³ Minno and Davis⁴ reported "...prompt relief of itching...in nearly every case..." and complete clearing in all 42 cases.

NEUTRAPEN is well tolerated when used intramuscularly and "...virtually nontoxic [pharmacologically], even at dose levels several hundred times the minimum effective dose."²

Indications

Therapeutic: NEUTRAPEN is indicated for the treatment of the allergic reactions to penicillin, such as urticaria,

angioedema, serum sickness, exzematoid and exfoliative dermatitis.

Diagnostic: Zimmerman suggests that "...response [to NEUTRAPEN] may be considered a useful tool in the differential diagnosis of eruptions where penicillin is only one of several possible inciting allergens."²

dosage and administration NEUTRAPEN, 800,000 units I.M., injected as soon as possible after symptoms of penicillin reaction appear. If necessary, dosage may be repeated at 3-day to 4-day intervals. In anaphylactic reactions occurring an hour or more after penicillin is given, therapy with NEUTRAPEN should immediately follow routine emergency measures. As soon as possible 800,000 units should be given intravenously followed by another 800,000 units intramuscularly.

contraindications and side effects No specific contraindications. Some soreness at the site of injection, which may be accompanied by erythema and local edema, may be noted in some patients, but it is transient and not serious. The use of penicillinase has been reported to cause transitory chills and fever in some cases.

supplied NEUTRAPEN is supplied in single-dose vials containing 800,000 units of purified injectable penicillinase as lyophilized powder. It is stable at room temperature in the dry state.

references: (1) Becker, R. M., *New England J. Med.* 254:952, 1956. (2) Chen, J. Y. P.; Ravid, J. W., and Robins, A. A., in Welch, H., and Marti-Ibanez, E., *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 321. (3) Zimmerman, M. C., in Welch, H., and Marti-Ibanez, E., *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 312. (4) Becker, R. M.: A New Concept in Treatment of Penicillin Reactions—Use of Penicillinase, paper presented at 196th Ann. Meet., A.M.A., New York, N. Y. June 5-7, 1957. (5) Becker, R. M., in Welch, H., and Marti-Ibanez, E., *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 318. (6) Minno, A. W., and Davis, G. M.: *J.A.M.A.* 161:222, 1957. (7) Davis, G. M.: *Biochemistry, Antibiotic Symposium*, Washington, D. C., October 3, 1957. (8) Zimmerman, M. C.: *Clin. Med.* 5:393, 1958.

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pitals and intend to limit my work entirely to these two hospitals, I'll be able to get one doctor having the same hospital affiliations to take over for me.

Fees

I started out by trying to compromise on fees between city and suburb.

In the suburbs nearest the city, OB men were charging \$200 for complete maternity cases. In more distant suburbs, the fee was \$150. I split the difference; made my fee \$175.

I've since raised it to \$200. Since

the general practitioners in the area were charging \$125-\$150, I was not and didn't want to be in competition with them.

My office visit fees are in accord with those of other physicians in my area. The fee varies on first, second, and subsequent visits according to what is involved in the treatment.

I handle my own billing and bookkeeping though I suppose I will need some help in the next few months or so. I certainly hope so, anyway. It would make me feel that I had truly *arrived* if I could justify bookkeeping assistance to keep all my patients' records in order.

AGE OF SPECIALIZATION

Herodotos, (484-425 B.C.) commented on Egyptian medicine: "The art of medicine among them is distributed thus: each physician is a physician of one disease and no more; and the whole country is full of physicians, for some profess themselves to be physicians of the eye, others of the head, others of the teeth, others of the affections of the stomach and others of the more obscure ailments."

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*Complete bibliography available on request.



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Medical Ethics and Etiquette

Perrin H. Long, M.D.

The intent of this section is quite clear, but the young physician must familiarize himself with local regulations and ethical considerations relative to what constitutes professional income. For example, in New York City (and possibly elsewhere in the State of New York) in municipal hospitals, patients who are able to pay a professional fee must pay this fee to the attending physician who was considered to be directly responsible for the care of the patient.

The question has been raised as to whether or not the intern or resident should receive this fee. This is an interesting point because it is often the house officer who renders by far the greater part of the service to the patient.

Another source of income which may be considered professional, and about which questions may arise, is that derived from royalties from copyrights or patents. Currently, it would appear that ethical standards are not violated if a doctor receives a fee for writing papers for a medi-

SECTION 7. In the practice of Medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee will be commensurate with the services rendered the patient and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided that it is in the best interests of the patient.*

cal journal, quasi-medical journals, scientific publications, or articles for lay consumption in the public press. The same holds true for royalties received from copyrights on textbooks, etc.

Whether it is ethical for a physician or surgeon to receive income from patents on drugs, remedies or devices is a moot question still before the medical profession. Formerly, the patenting of drugs or appliances was considered to be an unethical practice. Now that is not so considered. There are good rea-

*Principles of Medical Ethics, J.A.M.A. 164:1484 (July 27), 1957.

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sons and arguments for patenting a drug or a device, and there are good ones for the fact that a physician should not profit from his original development of drugs, remedies, instruments, or devices.

Royalties

These discussions have developed primarily in academic, institutional, or research environments, and where decision has been taken on these points and policy established, in certain instances the decision has been to urge the inventor to patent his drug, remedy or device, and then assign the patent to the university's research foundation, and in others to declare the patent open for public service. Of course, in the pharmaceutical or chemical industry, the patent would be assigned to the employing company.

This question of patenting is a difficult one. As all know, it is not beyond the realm of possibility that a physician might discover a drug which could return him millions of dollars per annum in royalties for the life of his patent. The physician who invented it would have to permit pharmaceutical companies making it to sell it at a price which would be profitable to them. The doctor could refuse royalties, he could reduce them to a low level, or he could request standard royalties, which he could dedicate to furthering medical research. There are so many factors involved in this problem that a firm answer has not yet

been established by our profession.

It is generally believed that it is unwise for doctors of medicine to own drug stores while in the practice of medicine — although there is currently nothing unethical about this as long as there is no evidence of exploitation of patients.

Furthermore, it is considered unethical, and in certain states appears to be illegal, for doctors to band together to form pharmaceutical organizations, and then use their own company's products exclusively. It is also considered unethical for physicians to organize or own stock in companies which operate clinical laboratories, clinics, or hospitals for profit because essentially what this is, is fee-splitting.

However, as far as current thinking is concerned, there is nothing unethical about doctors owning stock in recognized ethical pharmaceutical companies so long as no unusual control of the company is exercised by the doctor and no subterfuge is used in employing its products.

Charges

A doctor should be paid on the basis of the service he renders, and the ability of the patient to pay. This means, logically, that some patients will be treated without charge, some will pay very minor or moderate charges, and that others will pay larger fees.

However, it should be pointed out that occasionally physicians do our profession a great deal of harm by

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws, but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.*

outrageous charges. *Physicians should not charge all that the traffic will bear if they want our profession to survive in this day and age.* Nothing helps the proponents of "socialized medicine" more than over-charging.

As most of the outlandish bills are rendered to hospitalized patients, one way of coping with the situation is to have the governing board of a hospital put a ceiling on fees which may be charged to patients in that hospital. One of the most famous hospitals in the world has had a fee limit of \$2000 for the single entry of a patient (for semi-private patients in this same hospital total professional fee charges may not exceed \$150 for a single entry). This plan has worked out well over the years.

Fee-splitting ("commission for referral of patients"), rebating, giving discounts, loans, gifts, or emoluments is unethical unless the patient is completely aware of it, and agrees that a referral commission may be paid. Doctors who indulge in fee-splitting are greedy. They place the desire for profit above the opportunity to render appropriate medical service to their patients.

The arguments against fee-splitting are simple. First, as the referral commission comes out of the patient's pocket, if he is not aware that he is paying it, it is simply stealing from him. Secondly, a fee-splitting arrangement often reacts unfavorably against the patient, because the referring doctor is motivated more by the desire to receive a commission, than by the desire to do the best he can for his patient. Hence, he may not send him to the most able physician in the community.

Fee-splitting is still rife in many parts of this country, but with increasingly numerous medical societies embracing the so-called "Columbus Plan" to cope with this most dishonest and evil practice, it probably will eventually disappear.

Discussion

Fees should be discussed with patients or their relatives. A great deal of misunderstanding which develops between doctors and patients could be eliminated if patients could be given a rough idea of what

a given medical service was going to cost them.

Rebates on prescriptions, or devices, division of income equally within a partnership, paying for a practice on a fixed percentage basis of the income from the practice, paying a commission to a hospital, accepting commissions from nurses, technicians, etc., or contracting for or accepting a fee contingent on the outcome of litigation, all of these situations are considered to come under the heading of fee-splitting and are considered unethical.

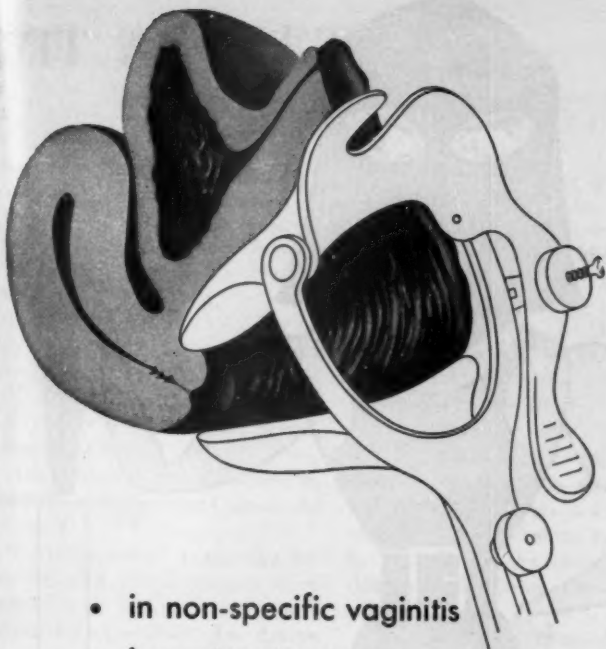
When more than one physician attends a patient, separate bills should always be rendered unless the patient or insurance company requests a single bill. A bill may be itemized or not. Anesthesiologists, roentgenologists, and pathologists should always render separate bills for their services (in some states it is illegal to do otherwise). A surgeon and his assistants should render separate bills.

Dispensing

The last part of this section deals with dispensing drugs, remedies and/

or appliances. Your Editor comes from a line of general practitioners in Ohio who have been dispensing physicians for more than a hundred years. People in that part of Ohio went to doctors because they didn't feel good, and wanted to get medicine with which to alleviate or cure their aches, disease, or pains. They knew that they had to pay for their medicine, or their glasses, or their trusses, and they did. But they didn't pay for medical "advice" unless they went to see a "specialist" or a "diagnostician." I remember well a patient who refused to pay my bill for a physical examination some thirty years ago in Ohio because I didn't give him any "medicine." Of course, an operation was different. Here the surgeon did something himself, so he could be paid for it. To my mind, the dispensing physician will gradually disappear as patients become better educated and realize that it is best to pay the doctor for his "know how" and the pharmacist for his ability to provide all things which the doctor orders. It's better not to have the doctor and the druggist in competition.

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IMFOR REGRET

Led by humane motives to invent a machine of death, this French physician is remembered not for his compassion for humanity, but only because of his machine.

Edward R. Bloomquist, M.D.

July 14, 1789.

The French Bastille crashed to earth; its reverberations shook the world.

For Frenchmen, it was the beginning of a bloody revenge upon nobility who had kept them in a living hell of serfdom. For France itself, a chance for freedom. For one of its citizens, Joseph Ignace Guillotin, an opportunity for greatness—an opportunity that would lead to a time for regret.

Study

Born May 28, 1738 at Saintes in Poitou, Guillotin grew and matured in the association of a good family, the loved and respected son of his lawyer father.

After diligently studying theology under Jesuit instructors in Bordeaux he was offered a professorship at Irish College. However the Jesuits

were suppressed in France, and Guillotin, influenced by this change of events, resigned his position. He subsequently traveled to Paris and in 1763, under the instruction of Antoine Petit, began the study of medicine.

Because of the tremendous expense involved in obtaining a degree in this city, he transferred to Rheims, receiving his doctor's hat there. He then returned to Paris, and entered a competitive examination for an endowed position created for needy and competent medical students. Acquiring this position, he was admitted to instruction leading to all the medical degrees Paris had to offer.

Doctor

On October 26, 1770, he was named doctor by Poissonnier and granted the privilege of practicing

in Paris, an honor since Parisian physicians were a select guild of teacher-clinicians numbering less than one hundred fifty members.

With little difficulty Guillotin reached high medical distinction and enjoyed great popularity as a professor. His private practice grew and prospered.

During this period a strange, unpredictable man entered Paris, exciting the populace and penetrating Royal circles with a new theory of disease and its cure. The reputation of his universal remedy spread through France, bringing him a large, wealthy clientele who showered him with riches and adulation.

His name—Franz Anton Mesmer.

In 1784, Louis XVI demanded a scientific evaluation of Mesmer's theory. Guillotin was appointed to a committee consisting of four members of the Paris faculty chosen to investigate this theory. After laboring diligently for six months, they returned an opinion that Mesmer was a quack advocating a dangerous treatment. In August of that year, Mesmer left Paris in disgrace.

Restless

Guillotin was now in his forties and looked years older than his actual age. He had married Marie Louise Sangrain, a bookseller's daughter, and was enjoying a successful career. But his restless spirit would not be denied. The practice of medicine was to be but one area of interest in his active life.

Although it was not his intention to be a politician, he was caught up in the surge of enthusiasm the common people were expressing in behalf of fair and equal representation in their government. At the time, representatives were puppets of the nobility and clergy. Frenchmen wanted a change.

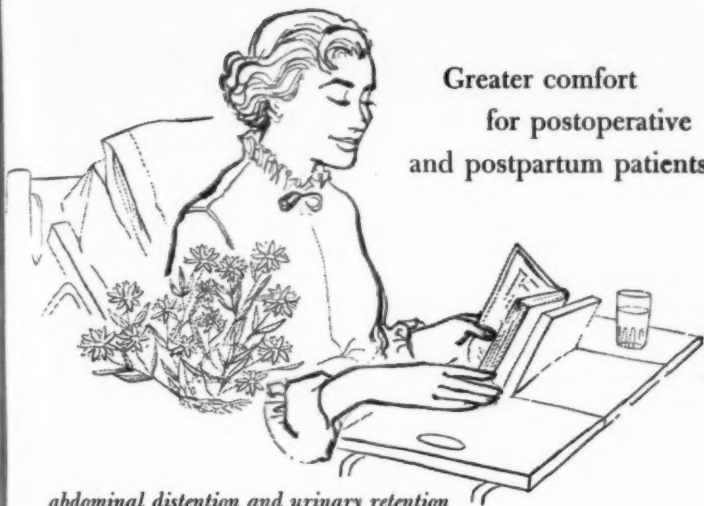
Pamphlet

On December 8, 1788, Guillotin, filled with sympathy for the cause of freedom, published a pamphlet setting forth the hopes and wishes of the French people. He could not know it at the time, but the philosophy expressed in his paper was destined to be one of the first political platforms of the French Revolution.

On December 19, Parliament confiscated the pamphlet, an action which only served to give added credence and importance to the document. Its suppression on the very eve of the Revolution caused discussions regarding the precarious position of the previously guaranteed freedom of the press. It was correctly reasoned that if the press could be smothered it would not be long before freedom of assembly and petition would also be eliminated.

With public pressure mounting, Parliament summoned Guillotin for interrogation. In a calm, urbane manner he declared his patriotism, swearing that in writing the pamphlet his only concern was for the

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French people. Undaunted by Parliament's disapproval, he offered to explain each point showing reasons why he drew his conclusions.

Deputy of Paris

His influence was significant. The following year Parliament asked the King to convene the States-General, an assembly composed of deputies of the three estates: nobility, clergy and bourgeoisie. Although the States-General had no legislative power, it could and did express the will of the people. This was frequently annoying to the King, in whose hands rested the sole authority of convening this assembly. Preceding Kings resolved their annoyance by failing to call further meetings, consequently, none had been in session since 1614.

Assembled again in 1789, the deputies did away with the States-General and organized the National Assembly. Guillotin, representing Paris, was elected a deputy to this body.

Within weeks after his appointment, he made his presence known because of objections to conditions forced upon the people's representatives. Working up to twelve hours a day on backless, cushionless seats, packed so close it was difficult to breathe, the representatives found their work impossible. When this problem was corrected, he next attacked the hearing and ventilation system in the assembly room which was invariably torrid in summer

and freezing in winter. He succeeded again, establishing the principle that it was insulting to all the French people for their representatives to be subjected to such shoddy conditions.

Working in Government affairs brought Guillotin into closer contact with a problem long a source of concern. Although France was advanced in other ways, it still retained medieval methods of capital punishment.

Punishment

Lacking refinements enjoyed by twentieth-century America whose society dispatches its capital criminals by electrocution, cyanide suffocation, the hangman's rope or the fatal lead poisoning of a firing squad, France employed more imaginative methods.

Condemned Frenchmen of that era faced rugged, varied experiences at the hands of the executioner. Nobility was granted an exclusive exodus via the headsman's axe or sword.

The bourgeoisie were less fortunate. Depending on the whim of the jurist, they could be drowned, burned, buried alive, broken on the wheel or drawn (disembowled) and quartered (dismembered).

To thinking people the system was repulsive. But public inertia and the sadistic tendencies of a few perpetuated the brutal performances.

Guillotin was made of sterner

stuff, however, and finally decided to attempt a revision of the sordid execution laws. On October 10, 1789, he introduced a group of ten articles to the Assembly supporting the principle that all men condemned to die, regardless of rank or position, should have the benefit of a "swift, humane execution."

Quick and accurate

Although decapitation seemed the most satisfactory method available, Guillotin was disturbed at the common practice of an executioner hopefully hacking away at his victim's neck with an axe. This system was messy, inaccurate, and if the victim did not remain calm and cooperative, the executioner was often forced to try, try again. One of the bloodiest examples of this was the execution of the Marquis de Thou who required eleven sword strokes before his decapitation was completed.

Project

Guillotin contended that if a vengeful public must have executions, they should be quick, simple and accurate. He proposed doing away with all current methods and asked the state to devise an uncomplicated, foolproof execution machine.

He also petitioned the Assembly to grant mercy to the family and heirs of the condemned and cease depriving them of their property and self respect as had happened

in the past. Further, he expressed hope that the occupation of public executioner, a position passed down from father to son, would be relieved of some of its stigma.

His ideas were received with sufficient sympathy that on December 21, 1789 the Assembly voted to abolish class distinction as it related to execution and asked the government to take steps to acquire an effective decapitation machine.

The resolution was passed along to His Majesty, Louis XVI, who in turn deposited the problem in the lap of his personal physician, Antoine Louis. Louis began the unpleasant task by getting the views of Henri Sanson, hereditary executioner of France. Sanson was only too happy to discuss the problems pertinent to his peculiar calling.

Armed with these facts, Louis made a careful anatomical study of the difficulties of decapitation and then consulted a German musical instrument maker, Schmidt, for mechanical advice.

Machine

The final apparatus was quite simple. It consisted of a table upon one end of which was attached two vertical posts, paralleling each other and grooved from top to bottom. The uprights were united at the top by a cross beam and a wooden collar ran between them where they joined the table. Suspended between the posts, high above the collar, was a broad steel blade heavily

weighted with lead. When released by a trigger mechanism, the blade traveled down the grooves with increasing speed, severing anything in its path.

Louis XVI was fascinated with this new device. He even noted a detail which had escaped the designers. He pointed out that persons possessing short, thick necks such as himself could not be eliminated with quite the dispatch guaranteed to those with thin, lean ones. To correct this the monarch suggested putting the blade at an angle so it would slice rather than crunch.

Dr. Louis failed to see the logic of this, but Sanson, far more experienced, was immediately enthusiastic. Pleased, the King took a pencil and obligingly diagrammed his idea.

A final test, accomplished on five deceased patients of the hospital at Bicêtre, proved Louis XVI's idea to be a logical one. Unwittingly, His Majesty had also done himself a favor. Within nineteen months he had opportunity to personally test his innovation.

Rapid

The machine now was ready for public exhibition. On April 25, 1792, a highwayman, Jacques Pelletier, was executed at the Place de Grève. Pelletier was probably glad to get it over with inasmuch as he had been kept waiting an additional two months while the machine was being completed.

An enormous crowd gathered to watch the event. Vengeful, blood thirsty, they were doomed to disappointment. The execution was rapid and without incident.

This disappointing feature might have caused the machine to be discarded had not its potential for rapid mass executions appealed to the mobs which ravaged France during the terror of the French Revolution.

From October, 1793, until the bloody knife had impersonally lopped off the heads of the same fanatics who had put it to its most vigorous use, the machine's tall somber spires could be seen in nearly every major city. Set in the center of the town where all could 'enjoy' the spectacle, it was kept busy separating the heads of unfortunate aristocrats from their bodies. Trundled to the place of execution through jeering mobs, victims arrived in groups of as many as seventy, numbly watching the blood wet knife as it rose and fell at the command of its masters, waiting their turn to bow their neck to the blade.


In a period of two years some 4000 men, women and children died, Paris alone accounting for over 2800.

Name

The apparatus was at first dubbed 'La Louise', or 'La Petit Louison' in honor of the surgeon who developed it. But this was short lived.

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Inasmuch as Frenchmen were frequently named Louis or Louise, a loud clamor soon arose to change the name.

For a while it was called the 'Eternal Widow' a nickname which remained. Its final title, however, materialized as a bit of doggerel appearing in a Royalist newspaper, *Journal des Actes des Apotres*. Entitled "L 'Inimitable Machine du Medicine Guillotin" it stated in essence that one morning a politician-physician, Guillotin, came to the conclusion that hanging was inhuman and unpatriotic. So, he devised a mode of execution without rope or sword which would kill simply. It should, therefore, be named 'Guillotine.'

Thus, without warning, an unkind destiny tagged the name of a well meaning humanitarian with tragic immortality.

Death sentence

Ignoring personal safety, Doctor Guillotin remained staunchly Royalist during the Terror. He persisted in wearing a powdered wig and three-cornered hat although such a show of Royalist sympathy could easily have cost him his life. During a time when everything relating to the King was being destroyed, Guillotin kept busts of nobility in plain sight in his home.

He publicly denounced Robespierre and Maret. In despair from seeing his humanitarian attempts distorted, he frequently cried that

no revolution was justified if it cost a single drop of human blood.

Somehow he managed to escape condemnation for a time. Other physicians, the majority of whom shared his political views, were not so fortunate. More than 100 physicians, among them Antoine Louis, were guillotined. Hundreds of others were expatriated.

Guillotin, himself, finally went too far. Refusing to disclose the location of the family of the condemned Count Mere who had placed them in Guillotin's hands for safe-keeping, Guillotin was tried and sentenced to death. His life was miraculously spared by the timely demise of Robespierre who was dragged, screaming and cursing, to the machine which had served him so well. With his death on July 27, 1794, the bloody Terror of the French Revolution came to an end.

Although Guillotin's political life had been disappointing, the elderly man still had a part to play in his country's future. Painstakingly, he gathered together a remnant of the old Paris medical faculty, organizing them into the Academie de Medicine. Through his efforts, medical students were introduced to bedside as well as lecture room instruction. His influence also led to the combination of physicians and surgeons into one medical group.

On the verge of retirement, he was again catapulted into national prominence by accepting and promoting the work of Edward Jenner

and his theory of vaccination against smallpox.

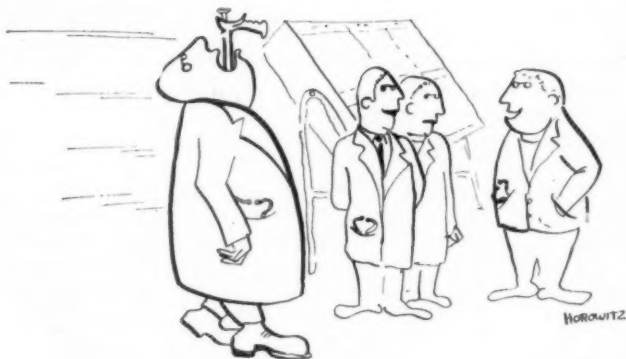
Regret

Guillotin died at the age of 76 on March 26, 1814, from anthrax of the left shoulder. Although he contributed much to his country and to the world as a patriot, physician and unselfish politician, he was, nevertheless, unable to remove the blot of association with the infernal machine from his name. The discredit was so great that after his death his children were pressured to change the family name.

Some historians feel that Guillotin in reality *saved* many lives during the Terror with 'his invention.'

Had it not been for the fascination of the guillotine, mob violence could easily have sent thousands of additional victims to a crueler fate.

Yet, for the most part, the historians have not been kind to Joseph Ignace Guillotin. Error and misinterpretation have given us a grossly inaccurate picture of a well meaning benefactor. Intensely interested in eliminating the barbaric fumbling which accompanied the executions of France, he suffered personal humiliation and degradation because he accomplished his aim. For what was essentially his greatest humanitarian act, Dr. Guillotin served a personal sentence of many years—a time for regret.



It certainly is nice of Dr. Crudwork to bring his own gastroscoposcope.

Mediquiz



These questions were prepared especially for RESIDENT PHYSICIAN by the Professional Examination Service, a division of the American Public Health Association.

Answers will be found on page 137

1. Diabetes mellitus may occur as a facet of an underlying disorder. Which one of the following groups of conditions contains only such disorders?

1. Cushing's syndrome, Addison's disease, Fanconi's syndrome, chronic pancreatitis.

✓ 2. Cushing's syndrome, acromegaly, hemochromatosis, chronic pancreatitis.

3. Pheochromocytoma, Cushing's syndrome, adrenogenital syndrome, Addison's disease.

4. Acromegaly, hemochromatosis, chronic pancreatitis, islet cell adenoma.

5. Renal glycosuria, acromegaly, hemochromatosis, Cushing's syndrome.

2. The serum cholesterol in myxedema is usually:

1. Normal.

2. Depressed.

3. Mostly in the unesterified fraction.

✓ 4. Elevated.

5. Confined mainly to macromolecules of the Sf 50 to 80 class.

3. A 35-year-old male who has a perforating foot ulcer, shooting pains about the body, and deafness suffers most likely from:

1. Polyneuritis.

2. Multiple sclerosis.

3. Syringomyelia.

4. Leprosy.

✓ 5. Hereditary sensory radicular neuropathy.

4. A patient has irregular nodding movements of the head or grimacing. The most outstanding feature, however, is incoordination of voluntary movements. There is absence of knee jerks, deformity of the feet and scoliosis. All of the above symptoms should point to a diagnosis of:

1. Hysterical fit.

2. Epilepsy.

3. Parkinson's disease.

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4. Spasmodic torticollis.
- ✓5. Friedreich's ataxia.

5. Anesthesia and analgesia of the sole of the foot and plantar surfaces of the toes indicates interruption of the:

- ✓1. Tibial or the posterior tibial nerve.
2. Common peroneal nerve.
3. Deep peroneal nerve.
4. Entire femoral nerve.
5. Superficial peroneal nerve.

6. In most cases of osteomalacia due to renal acidosis, the renal disease responsible is:

1. Lipoid nephrosis.
2. Chronic glomerulonephritis.
3. Malignant nephrosclerosis.
4. Intercapillary glomerulosclerosis.
- ✓5. Chronic pyelonephritis.

7. Subjects who are alive at 17 years of age with an open ductus arteriosus have a subsequent life expectancy which averages:

1. One-tenth that of the general population.
2. One-fifth that of the general population.
- ✓3. Half that of the general population.
4. Four-fifths that of the general population.
5. That of the general population.

8. Periarteritis nodosa differs from cranial arteritis in that in the latter:

1. There is a poor prognosis as to life expectancy.

2. The incidence in young women is high.

✓3. There is usually localized involvement of the temporal arteries.

4. There is a leukocytosis with fever.

5. No bacteria are characteristically isolated from the lesions.

9. In congestive heart failure the bilirubin content of the blood is nearly always raised and clinical jaundice may be present. In addition to excess blood destruction, a factor responsible for this form of bilirubinemia is:

- ✓1. Anoxemia of the liver cells due to venous stasis.
2. Obstruction of bile ducts due to congestive swelling.
3. Toxic necrosis of liver cells due to reduced kidney function.
4. Reduced circulation with a reduction in bilirubin passed through the kidney.
5. Anoxemia of kidney cells with resultant reduced bilirubin excretion.

10. The presence of precordial distress, pericardial friction rub, and elevation of the RS-T segment is often seen in:

1. Inactive rheumatic heart disease.
2. Pulmonary infarction.
- ✓3. Acute pericarditis.
4. Angina pectoris.
5. Essential hypertension.

RP REVIEWS
BOOKS

About Doctors

Conducted by SAUL A. KUCHINSKY

SURGEONS ALL. *Graham, Harvey.*
N. Y., Philosophical, 1957. 459 p.
\$10.

An historical survey of surgery and much of medicine, here is the story, erudite, charming, witty, of the Biblical "giants in the land," those dozen or more selfless men whose lives brighten the pages of surgical and human annals. From their devotion, surgery evolves, grows, "is a story full of hope that remains always unfinished."

Here we meet Avicenna, Prince of Physicians, who at 21 produces a synopsis of all the known sciences and, in his lifetime, 99 books on subjects ranging from medicine to metaphysics. Here, too, are the half-legendary Aesculapius, father of the caduceus; the medieval anatomist Vesalius, who breaks a 1,300-year enslavement to Galen with observation based on human dissection. And Ambröise Paré ("I dressed him and God healed him"), William Cheselden, Percivall Pott ("My lamp is almost extinguished. I hope it has burned for the benefit of others"), the indefatigable John Hunter, who knew that the surgeon must study all the biological sciences. One of



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the first surgical residents in history, Hunter, at London's St. George's Hospital, received no salary, paid 10 pounds a year for board, was treated generally as an "upper servant." Gunning, Cooper, Liston and Syme join the honor roll.

Here also is the telling of the incredible obstacles against which these great men set themselves. The dissection of human corpses raises a cry among the people and actual physical attack on the men who would study physical man in the one indispensable manner. Handling of women patients is obstructed by society's code of false modesty. Tinkers, barbers, painters, dog-leechers, sow-gelders, cobblers, charlatans and quacks must be separated from surgery. But the separators, even some of the great ones, are often as ignorant as those being separated. They, too, defend "The Royal Touch" as cure for scrofula, "laudable pus" in infection, spear-salve for the spear that caused the wound.

And here, also, are the often heroic victims of disease, the commoners and kings who endure major operation without anesthesia, and death by the million.

But when Lister and Morton pass the barriers of sepsis and pain and Roentgen discovers his x-ray, the tide of man's medical salvation rolls to flood.

Here, finally, the best story of all, the varied medical disciplines working as a team for the first time in man's hectic war with disease.

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VIEWBOX DIAGNOSIS

(from page 21)

SIMPLE OSTEOMA

Note smooth bony mass arising from the left temporal bone, formed by bone trabeculae similar to the temporal bone.

MEDIQUIZ ANSWERS

(from page 128)

1 (2), 2 (4), 3 (5), 4 (5), 5 (1),
6 (5), 7 (3), 8 (3), 9 (1), 10 (3).

RESIDENT RELAXER

(puzzle on page 25)

N	I	D	U	S		J	U	T	E		A	T	O	M
I	N	U	L	A		U	V	E	A		C	O	D	E
C	R	O	O	N		T	A	R	S		E	L	O	D
K	O	S	S	E	L	S		M	I	S	T	U	R	A
						I	M	A	U	M		N	E	O
P	U	S	S	A	C			O	R	G	A	N	O	I
O	R	A			N	U	R	S	E		T	E	T	R
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D	E	C	U	B	I	T	U		M	E	G	R	I	M
						M	E	D		S	L	I	D	E
B	L	E	E	D	E	R		O	S	A	M	I	N	E
R	O	A	N		A	E	B	Y		T	I	N	E	A
A	B	R	I		T	E	L	A		E	N	T	A	D
D	I	S	C		E	S	E	L		D	I	O	R	S

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